STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 005807
REG. NO.

023507 FEB 2389

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ALFRED — MIDDLE: E. — LAST: GORDON
2a. DATE OF DEATH — MONTH DAY YEAR: 2.13.89
2b. HOUR: 9.34 P.M.
3. SEX: Male
4. RACE: Afro-American
5. DATE OF BIRTH — MONTH DAY YEAR: March 4 39
6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Spotsylvania
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.
10. CITY OR TOWN OF DEATH: CLINTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SO. MARYLAND HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: P. G.
13c. CITY OR TOWN: UPPER MARLBORO
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS (ZIP CODE): 11308 CRANFORD RD. 20772

14. FATHER'S NAME — FIRST: Ernest — MIDDLE: John — LAST: Gordon
15. MOTHER'S MAIDEN NAME — FIRST: Pearl — MIDDLE: — LAST: Comfort
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 227-46-1595
17. INFORMANT — ADDRESS: Verna E. Gordon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): End stage Alcoholic Liver disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/29/89 to 2/13/89, that (I) (we) last saw the deceased alive on 2/13/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 18, 1989
23c. NAME OF CEMETERY OR CREMATORY: Gordon Family Cemetery
23d. LOCATION — CITY OR TOWN: Spotsylvania — COUNTY — STATE: Virginia
24. FUNERAL DIRECTOR (SIGNATURE): Thomas [illegible]
ADDRESS: Orange, Virginia 118 E. Church St.
25a. DATE REC'D. BY REGISTRAR: FEB 21 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landess

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

024791 MAR 7 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 055803

1. DECEASED NAME (TYPE OR PRINT): FIRST ~~ARTHUR~~ Arthur MIDDLE L. LAST GOSNELL

2a. DATE OF DEATH: MONTH February DAY 15 YEAR 1989

2b. HOUR: 10:15a

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH Oct DAY 19 YEAR 1912

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George County MD.

10. CITY OR TOWN OF DEATH: Laurel

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel - Beltsville Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Silver Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 12729 Bexley Terrace 20904

14. FATHER'S NAME: FIRST Albert MIDDLE LAST Gosnell

15. MOTHER'S MAIDEN NAME: FIRST Hattie MIDDLE LAST Millard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216 -44- 3128

17. INFORMANT: Mae B. Gosnell ADDRESS: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Acute & Chronic Uremic Nephropathy
DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes Mellitus Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Septicemia ~~with~~ Liver failure

19a. DATE OF OPERATION: Autopsy

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. 11:15 P.M. MONTH 2 DAY 15 YEAR 1989

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-07 19 89 to 2-15- 89 that (I) (we) last saw the deceased alive on 2-15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Jon Manam

22e. ADDRESS: 3450 Ft Meade Rd to 725 Laurel MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb 17, 1989

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION: CITY OR TOWN Brentwood COUNTY Maryland STATE

24. FUNERAL DIRECTOR: NAME Donaldson Funeral Home P.A. ADDRESS Laurel, Maryland

25a. DATE REC'D. BY REGISTRAR: 3/21/89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please have carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, other traumatic event, the medical examiner must be notified and will retain this certificate.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

(20) BP

DHMH - 16 80M 7/84
(VRA 15. 4)

Donaldson F.H.

024595 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053097 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: KITTY	MIDDLE: M	LAST: GRAY	2a. DATE OF DEATH MONTH DAY YEAR: 02-27-89	2b. HOUR: 2.50 PM
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: 06 14, 1893	6. AGE (IN YEARS LAST BIRTHDAY): 95 yrs YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va.	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH: FORT Washington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FORT Washington Rehab. Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: P G	13c. CITY OR TOWN: OXON HILL	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 1313 SOUTHERN AVE OXON HILL MD 20745	
14. FATHER'S NAME FIRST: Walter	MIDDLE: S.	LAST: Reese	15. MOTHER'S MAIDEN NAME FIRST: Rachel	MIDDLE: Harriston	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 236-92-9644	17. INFORMANT ADDRESS: Grace Diggs-Same as # 13 above			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerotic DISEASE OF

DUE TO, OR AS A CONSEQUENCE OF (c): HEART AND BRAIN

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6, 19 88, to 2/27, 19 89, that (I) (we) last saw the deceased alive on 2/25, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/27/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LAXMI BERWA, M.D.	22e. ADDRESS: 1306 MERCANTILE LN., LANDOVER, MD		

23a. BURIAL, CREMATION, REMOVAL (FACILITY)	23b. DATE: 3/2/89	23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: BLADENSBURG, MD.	
24. FUNERAL DIRECTOR NAME / ADDRESS: H.S. WASHINGTON & SONS 4925 BENNING RD NE	25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall		

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

Va. x

Rehab. Center Homemaker Own Home

x

Walter S. Reese Rachel Harriston

No Grace Diggs-Same as # 13 above

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005810

024798 MAR - 7 89

2

1. DECEASED NAME (TYPE OR PRINT): FIRST Maurice MIDDLE Jerome LAST Grady
2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☑ MONTH 2 DAY 18 YEAR 1989
2b. HOUR
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH 07 DAY 28 YEAR 1922
6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 18 YEAR 1989
2d. HOUR 10A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
10. CITY OR TOWN OF DEATH: College Park
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9405 Baltimore Avenue #2
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Refinisher
12b. KIND OF BUSINESS OR INDUSTRY: Furniture

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland
13b. COUNTY: P.G.
13c. CITY OR TOWN: College Park
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 9405 Baltimore Ave. #2 20740

14. FATHER'S NAME: FIRST Samuel MIDDLE Jackson LAST Grady
15. MOTHER'S MAIDEN NAME: FIRST Georgie Lee MIDDLE LAST Clatterbuck
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes-Army (IF YES, GIVE WAR OR DATES): WWII
16b. SOCIAL SECURITY NO.: 579-16-3903
17. INFORMANT: (Wife) Shirley K. Grady ADDRESS: 213 Lakeside Drive #104 Greenbelt, Md. 20770

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ethylism
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diarrhea

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER
DATE SIGNED: 2-18-89
EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 02/21/89
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetry
23d. LOCATION CITY OR TOWN: Brentwood COUNTY: P.G. STATE: Maryland

24. FUNERAL DIRECTOR: Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781
25a. DATE REC'D. BY REGISTRAR: FEB 21 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4 25M BP

DHMH - 17
(VR A15 ME (5))

6
IVA

0249411 MAR 0 9

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 058111

1- FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Joseph MIDDLE X. LAST Grayson

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Feb 26 1989 (MONTH DAY YEAR)

2b. HOUR 6:22 A.M.

3. SEX M

4. RACE Blk

5. DATE OF BIRTH (MONTH DAY YEAR) Feb 13 12

6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.

IF UNDER 1 YR. (MONTHS DAYS) / IF UNDER 24 HRS. (HOURS MINS)

2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR) Feb 26 1989

2d. HOUR 6:31 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.

10. CITY OR TOWN OF DEATH Laurel

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meter Tester

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Md

13b. COUNTY Prince Georges

13c. CITY OR TOWN Bowie

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 6810 Normal School Rd

14. FATHER'S NAME: FIRST William MIDDLE LAST Grayson

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST Greene

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) N/A

16b. SOCIAL SECURITY NO. 107-14-8361

17. INFORMANT ADDRESS: Joseph H. Grayson 1221 Massachusetts Ave., N.W. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Dis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 yrs.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE A. L. Ryan M.D. TITLE (SPECIFY) Dep. MEDICAL EXAMINER

DATE SIGNED Feb 26, 1989

EXAMINER'S NAME (TYPE OR PRINT) ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE March 4, 1989

23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial

23d. LOCATION CITY OR TOWN Landover, COUNTY Maryland STATE

FUNERAL DIRECTOR (NAME) John T. Stewart, III ADDRESS 4001 Benning Road, N.E. Stewart Funeral Home Washington, D.C.

25a. DATE REC'D. BY REGISTRAR MAR 01 '89

25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 BP

DHMH - 17 (VR A15 ME (5))

3

022999 FEB. 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05312
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)	FIRST: JOSEPHINE; MIDDLE: ; LAST: GRECO
2a. DATE OF DEATH	MONTH: 2; DAY: 2; YEAR: 89
2b. HOUR	12 27 PM
3. SEX	female
4. RACE	white
5. DATE OF BIRTH	MONTH: Sept; DAY: 11; YEAR: 1906
6. AGE (IN YEARS LAST BIRTHDAY)	82 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George MD.
10. CITY OR TOWN OF DEATH	Laurel
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Greater Laurel Beltsville Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland
13b. COUNTY	P.G.
13c. CITY OR TOWN	Laurel
13d. INSIDE CITY LIMITS?	YES ☐ NO ☒
13e. STREET ADDRESS	16126 Kenny Road 20707
14. FATHER'S NAME	FIRST: Frank; MIDDLE: ; LAST: LaRosa
15. MOTHER'S MAIDEN NAME	FIRST: Antoinette; MIDDLE: ; LAST: Cucina
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	215-60-8103
17. INFORMANT	Danny Greco
ADDRESS	same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Breast Cancer
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): N/A

19a. DATE OF OPERATION	N/A
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?	YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from ? 1980's, 19____ to Present, 19____, that (I) (we) last saw the deceased alive on 2/1, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	[signature]
DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED	2/2/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	LUIS A CARAS MD
22e. ADDRESS	8317 CHERRY LA LAUREL MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	Feb. 6, 1989	23c. NAME OF CEMETERY OR CREMATORY	New Cathedral Cem.
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Baltimore / Md				
24. FUNERAL DIRECTOR NAME / ADDRESS	Donaldson Funeral Home P.A. Laurel, Maryland	25a. DATE REC'D. BY REGISTRAR	FEB 9 '89	25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 058 13

0234502 FEB 22 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Edith — MIDDLE: O — LAST: Green
2a. DATE OF DEATH — MONTH: January — DAY: 23, — YEAR: 1989
2b. HOUR: 1:45PM
3. SEX: F
4. RACE: BLK
5. DATE OF BIRTH — MONTH: 5 — DAY: 7 — YEAR: 17
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH: Easton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Talbot
13c. CITY OR TOWN: McDaniel
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: P.O Box 74

21647

14. FATHER'S NAME — FIRST: Clearance — MIDDLE: — LAST: Palmer
15. MOTHER'S MAIDEN NAME — FIRST: Laura — MIDDLE: — LAST: Cooper
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16b. (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 215-20-0133
17. INFORMANT — Charles Green — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute inferior Wall Myocardial infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 45m
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive Cardiovascular Disease — 20 yr
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Peripheral Vascular Disease with bilateral femoral occlusion

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/22/89 19__ to 1/23 19 89, that (I) (we) last saw the deceased alive on 1/22/89 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Wm H Wood — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED:
22d. PHYSICIAN'S NAME (TYPE OR PRINT):
22e. ADDRESS:

23a. BURIAL, ~~CREMATION, REMOVAL~~ (SPECIFY)
23b. DATE: 1/27/89
23c. NAME OF CEMETERY OR CREMATORY: Woodland
23d. LOCATION — CITY OR TOWN: Easton — COUNTY: Ta. — STATE: Md

24. FUNERAL DIRECTOR — NAME: George Dashiell — ADDRESS: Easton Md.
25a. DATE REC'D. BY REGISTRAR: FEB 01 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

24918 MAR-8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005814

1. DECEASED NAME (TYPE OR PRINT): FIRST Joseph MIDDLE J. LAST Green

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH Jan DAY 29 YEAR 1989 — 2b. HOUR

3. SEX: MALE — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH May DAY 11 YEAR 1929 — 6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH Jan DAY 29 YEAR 1989 — 2d. HOUR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: Clinton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital Center — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self Employed — 12b. KIND OF BUSINESS OR INDUSTRY: Oil Fuel Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. — 13b. COUNTY: Prince Georges — 13c. CITY OR TOWN: Fort Washington — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: 6509 Farmer Drive 20744

14. FATHER'S NAME: FIRST Ernest MIDDLE LAST Green

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST Brooks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 578-30-5433

17. INFORMANT ADDRESS: 6509 Farmer Drive Ethel Green Fort Washington, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [ ], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 1/30/1989

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: February 3, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Cem. — 23d. LOCATION CITY OR TOWN: Suitland COUNTY: Maryland STATE

24. FUNERAL DIRECTOR: John T. Stewart, III — ADDRESS: 4001 Benning Road Stewart Funeral Home Washington, D.C. — 25a. DATE REC'D. BY REGISTRAR: FEB 10 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

022966 FEB 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 39 05316

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If items marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: APHRODITE MIDDLE: Terry LAST: GREGORY			2a. DATE OF DEATH MONTH DAY YEAR: 1-29-89
2b. HOUR: 2.30P M	3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: December 23, 1923
6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.	10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Hostess
12b. KIND OF BUSINESS OR INDUSTRY: Restaurant	USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Hyattsville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: 6805 Darby Road 20784		
14. FATHER'S NAME FIRST: Terry MIDDLE: S. LAST: Gregory	15. MOTHER'S MAIDEN NAME FIRST: Rita MIDDLE: LAST: Vasso		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-24-5386	17. INFORMANT: (Sister) ADDRESS: 6805 Darby Road Antoinette T. Gregory Johnson Hyattsville, 20784	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PNEUMONIA	4 days
DUE TO, OR AS A CONSEQUENCE OF (b)	ASPIRATION	4 days
DUE TO, OR AS A CONSEQUENCE OF (c)	PARKINSON'S DISEASE	YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PRESSURE SORE OF SACRUM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from SPRING 19 88 to 1/29 19 89, that (I) (we) last saw the deceased alive on 1/27 19 89, and that (to my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/30/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): P SCHISLER MD	22e. ADDRESS: 7500 Greenway Ctr Dr Greenbelt MD 20770		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/02/89	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN: Suitland	COUNTY: P.G. STATE: Maryland
24. FUNERAL DIRECTOR NAME: Francis Gasch's Sons Funeral Home, P.A. ADDRESS: 4739 Baltimore Avenue Hyattsville, Md. 20781	25a. DATE REC'D. BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

022097 FEB-9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05816
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST HAZEL MIDDLE M. LAST GRENNON

2a. DATE OF DEATH: MONTH Feb DAY 3 YEAR 89

2b. HOUR 6:30 PM

3. SEX: FEMALE

4. RACE: White

5. DATE OF BIRTH: MONTH 02 DAY 20 YEAR 1926

6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Oklahoma

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George County MD.

10. CITY OR TOWN OF DEATH: Beltsville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10607 Hockberry Way

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk Typist

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govn't

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: P.G.

13c. CITY OR TOWN: Beltsville

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: 10607 Hockberry Way 20705

14. FATHER'S NAME: FIRST Ernest Franklin MIDDLE LAST Bird

15. MOTHER'S MAIDEN NAME: FIRST Ula MIDDLE LAST Hall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 448-18-2572

17. INFORMANT ADDRESS: William J. Grennon, Jr. (husband) same #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Carcinoma dueto — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 1/2 Years

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I)(this hospital) attended the deceased from 10-16 19 84, to 2-3 19 89, that (I)(we) last saw the deceased alive on 1-6-89 19 , and that in (my)(our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.

22b. SIGNATURE: Wm Flint Luckett — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2-4-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Wm Flint Luckett MD

22e. ADDRESS: 5001 Reno Rd NW Wash DC 20008

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-7-89

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION CITY OR TOWN: Brentwood COUNTY: P.G. STATE: Md.

24. FUNERAL DIRECTOR: Donald Borgwardt ADDRESS: 4400 Powder Mill Rd. Beltsville, Md. 20705

25a. DATE REC'D. BY REGISTRAR: 2-7-89

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024464 MAR -2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05817
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: GLADYS MIDDLE: LAST: GRUBNAU				2a. DATE OF DEATH MONTH DAY YEAR: 2-23-89	2b. HOUR: 5:10 PM
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: January 4, 1891	6. AGE (IN YEARS LAST BIRTHDAY): 98 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): So. Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince George's	Clinton	YES ☐ NO ☒	6907 Dalmaitia Drive 20375

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	ADDRESS
Thomas / / Jones	Elizabeth / Broadbent	7011 Dower House

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	198-03-9558	Raymond Johnson/Nep/Rd, Upper Marlboro, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Renal Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Dehydration

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Ischemic Cardiomyopathy; Compresseion Fx. L-1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐	2 9 1989	tripped and fell

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	9607 Dalmatia Drive, Clinton, Pr. Geo. MD

22a. I certify that (I) (this hospital) attended the deceased from Nov. 1988 to Feb. 23rd, 1989 that (I) (we) last saw the deceased alive on Feb. 23rd 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Victor S. Chupkovich MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Victor S. Chupkovich, M.D.	9131 Piscataway Rd., Clinton, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	March 1, 1989	West Laurel Hill	Philadelphia, Pennsylvania

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Cavanagh's Funeral Home, 6922 Woodland Avenue, Philadelphia, PA 19142	FEB 28 1989	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or physician. Page 4 must be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked on page 1, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024528 MAR 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 89 05813
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: COSTANTINO MIDDLE: LAST: GUADAGNOLI				2a. DATE OF DEATH MONTH DAY YEAR: 02 21 89	2b. HOUR: 2:15 P.M.
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 22, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES CO MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Package Store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Charles	13c. CITY OR TOWN: Waldorf	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: Highway 5, Box 283-A 20601	
14. FATHER'S NAME FIRST: Gabriele MIDDLE LAST: Guadagnoli		15. MOTHER'S MAIDEN NAME FIRST: Maria MIDDLE LAST: Di Domenico			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 018-30-8404	17. INFORMANT: Domenic Guadagnoli	ADDRESS: Highway 5, Box 283-A Waldorf, Md. 20601		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopnemonia Lt. Lung
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Ischemic Cardiomyopathy; Chr.Congestive Heart Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 87 to Feb. 21st 19 89, that (I) (we) last saw the deceased alive on Feb. 20, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Victor S. Chupkovich M.D. DEGREE: ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/22/1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Victor S. Chupkovich,M.D. — 22e. ADDRESS: 9131 Piscataway Rd., Clinton,Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/25/89	23c. NAME OF CEMETERY OR CREMATORY: St. Tarcisius Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Framingham, Ma.

24. FUNERAL DIRECTOR NAME / ADDRESS: Ives-Pearson Funeral Home, 2847 Wilson Blvd., Arlington, Va. 22201

25a. DATE REC'D. BY REGISTRAR: FEB 24 1989

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024983 MAR-8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

89 REG. NO. 005819

1. DECEASED NAME (TYPE OR PRINT): SAMUEL JACOB GUILER / SAMUEL J. GUILER				2a. DATE OF DEATH: 2-9-89	2b. HOUR: 930 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Sept. 22, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Maintenance Eng.	12b. KIND OF BUSINESS OR INDUSTRY: School	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	PG	Hyattsville	YES ☒ NO ☐	6106 42nd Avenue 20781

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
Harvey Guiler	Ida Thomas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW-2	577-38-7840	Berea, Ohio	Lois Ewers, 619 Ensenada Ct. 44617

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Acute Myocardial Infarction c/m Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Cardiovascular Disease.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
(1) Renal failure (2) Respiratory failure (3) Chronic obstructive lung (4) Upper Gastrointestinal Bleeding (5) Severe thrombocytopenia (6) Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-4- 19 89 to 2-9- 19 89 that (I) (we) last saw the deceased alive on 2-9- 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
M.A. Mannan	MD	☐ ☒ ☐	02-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MOHAMMED A. MANNAN	3715 - RHODE ISLAND AVE MT. RAINIER, MD. 20712

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	02-13-89	Metropolitan Crematory	Alexandria, Virginia

24. FUNERAL DIRECTOR (NAME / ADDRESS): FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 17 '89

25b. REGISTRAR'S SIGNATURE: Juha Davidson-Kendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

021948 FEB-8 09

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05820
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the [illegible] and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove [illegible] pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Bernadine	MIDDLE: M.	LAST: Guthrie	2a. DATE OF DEATH MONTH DAY YEAR: Feb 1 89
2b. HOUR: 2 PM			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 6 8 98	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.
IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS HOURS MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.
10. CITY OR TOWN OF DEATH: Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Carroll Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Mont.	Wheaton	YES ☒ NO ☐	12702 Feldon St. 20906

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Leo	C	Marsh	Bernadine		Fenwick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
N/A		579-42-0524	Mary Flynn (Daughter) Same as 13E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia — 24hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: General debility

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~the hospital~~) attended the deceased from Jan 19 86 to Feb 1 19 89 that (I) (~~we~~) last saw the deceased alive on Jan 31 19 89 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. I (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: James Foster MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/1/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. James Foster	916 19th St. N.W.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/3/89	Arlington Cemetery	Arlington, Va.

24. FUNERAL DIRECTOR ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md	FEB 6 1989	Barbara Davidson-Randall

024959 MAR-8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05821

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 should any injury or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret	MIDDLE: E.	LAST: GUY	2a. DATE OF DEATH MONTH DAY YEAR: February 21, 1989	2b. HOUR: 12:35 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 07 21 11	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctors' Hospital of PG County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Social Worker	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: Adelphi	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 7401 New Hampshire Avenue 20783	
14. FATHER'S NAME FIRST: Harry	MIDDLE:	LAST: Guy	15. MOTHER'S MAIDEN NAME FIRST: Edith	MIDDLE:	LAST: Van Vorce
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 058-03-9211	17. INFORMANT: Wanda G. Herrick	ADDRESS: Imperial Harbor Box 297 Bonita Springs, FL	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sepsis + Shock
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital) attended the deceased from January, 19 89, to Feb 21, 19 89, that (I) (we) last saw the deceased alive on Feb 20, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Stuart Turkewitz	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/22/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stuart Turkewitz, MD	22e. ADDRESS: 7500 Greenway Cntr. Dr. Greenbelt, Md. 20770		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/25/89	23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park	23d. LOCATION CITY OR TOWN: Falls Church	COUNTY / STATE: VA
24. FUNERAL DIRECTOR NAME: Francis Gasch's Sons Funeral Home, PA ADDRESS: 4739 Baltimore Ave., Hyattsville, MD 20781	25. DATE REC'D. BY REGISTRAR: FEB 28 '89	25a. REGISTRAR'S SIGNATURE: Josha Davidson-Randall		

BP

DHMH - 1650M 1/81 (VRA 15, 4)

(12)

024753 M 753

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05822
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
MARY	ELLA	GYURAS	FEBRUARY	23	1989	5:09 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	Caucasian	8-	25-	1944	44 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Florida	U.S.A.		Prince Georges MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Camp Springs	Malcomb Grow- Andrews AFB	Homemaker- Home	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20601

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Charles	Waldorf	YES ☒ NO ☐	5009 Albacore Ct.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Carl	L.	Fretwell	Mary	D.	Bunn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	1963-66	262-76-9549	Conrad P. Gyuras Same as # 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY TUMOR EMBOLI

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) BREAST CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 21 Feb 19 89, to 23 Feb 19 89, that (I) ~~(me)~~ last saw the deceased alive on 23 Feb 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(me)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Charles A. Weber	MD		23 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CHARLES A. WEBER, CAPT, USAF, MC	MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MD 20331-5300

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2-27-89	Md. Veterans Cemetery	Cheltenham Pr. Geo. Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home 6633 Old Alexander Ferry Rd. Clinton, Md.	MAR 01 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in obtaining a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

Item#'s 18a Part2 22a per med Film G649cg

0235555 FEB 22 89 FOR STATE REGISTRAR 3/29/89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05823

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	KNOWN ☒ ESTIMATED ☐	MONTH	DAY	YEAR	2b. HOUR
Doctor	SAMUEL	J.	HAGEN, Jr.			2	12	1989	M

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR)	2d. HOUR
Male	White	10- 28- 1919	69 YRS.					2 12 1989	4:29 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	United States		Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Laurel	Greater Laurel-Beltsville Hosp.	Doctor	Medical

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Maryland	P.G.	Beltsville		11617 35th Ave. 20705

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel	J.	Hagan, Sr.	Lydia		Maunz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WWII	111-09-6586	Virginia B. Hagan (wife) same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Complications of acute ethonal intoxication

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) _____

DUE TO, OR AS A CONSEQUENCE OF (c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-13-89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2-15-1989	Maryland Veterans	Cheltenham	P.G.	MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donald V. Borgwardt	4400 Powder Mill Rd. Beltsville, Md. 20705	FEB 17 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WITH THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: A CERTIFICATE SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP 365 DHMH - 17 (VR A15 ME (5))

023298 FEB 2

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05824
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST MILTON MIDDLE A. LAST HALL

2a. DATE OF DEATH: MONTH 02 DAY 09 YEAR 89

2b. HOUR 359 P M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH 06 DAY 30 YEAR 19

6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington DC

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.

10. CITY OR TOWN OF DEATH: Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Md. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Steam Fitter

12b. KIND OF BUSINESS OR INDUSTRY: Plumbing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: P.G.

13c. CITY OR TOWN: Bryans Road

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: 148 7-A Hampton Ct. 20616

14. FATHER'S NAME: FIRST William MIDDLE H. LAST Hall

15. MOTHER'S MAIDEN NAME: FIRST Minnie MIDDLE M. LAST Cook

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 579-10-0183

17. INFORMANT: Wilda M. Hall ADDRESS: Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): LUNG CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: PNEUMONIA

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/30, 19 89, to 2/9, 19 89, that (I) ~~(was)~~ last saw the deceased alive on 2/8, 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(was)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: [signature] M DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Phillip Wisotsky MD

22e. ADDRESS: 6188 Oxon Hill Rd. Oxon Hill Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 02/10/89

23c. NAME OF CEMETERY OR CREMATORY: Lee Crematory

23d. LOCATION: CITY OR TOWN Clinton COUNTY Prince George's STATE Md.

24. FUNERAL DIRECTOR (NAME AND ADDRESS): Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md 20735

25a. DATE REC'D. BY REGISTRAR: FEB 16 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21b is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

0229 78 FEB 15 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05825
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: NELLIE	MIDDLE: G.	LAST: HAMILTON	2a. DATE OF DEATH MONTH DAY YEAR: 2/7/89	2b. HOUR: 1.57P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 5, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Landover	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 8012 Sheriff Road 20785	
14. FATHER'S NAME FIRST: J.D.	MIDDLE	LAST: Hildreth	15. MOTHER'S MAIDEN NAME FIRST: Rosa	MIDDLE	LAST: Harrington
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-48-7138	17. INFORMANT: (Daughter) Shirley Hamilton	ADDRESS: 8012 Sheriff Road Landover, Md. 20785	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory anest
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1 26, 19 89, to 2 7, 19 89, that (I) (we) last saw the deceased alive on 2 7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Pimolvarn Limpuangthip	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/7/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): PIMOLVARN LIMPUANGTHIP	22e. ADDRESS: 6201 Riverdale Rd., Riverdale Md 20817		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 02/09/89	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory	23d. LOCATION CITY OR TOWN: Alexandria	COUNTY / STATE: Virginia
24a. FUNERAL DIRECTOR NAME / ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		24b. DATE REC'D. BY REGISTRAR: FEB 9 '89	25a. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024829 MAR -7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05326 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have cards typed. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Jessie Ellrod Haneke				2a. DATE OF DEATH MONTH DAY YEAR: February 16, 1989	2b. HOUR: 4:40P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 10, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Doctors Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Largo	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 600 Largo Road 20772	
14. FATHER'S NAME FIRST / MIDDLE / LAST: Frank Schrimser			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Harriet Waters		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----	16b. SOCIAL SECURITY NO.: 169-10-4455	17. INFORMANT: Fred E. Ellrod, Jr.	ADDRESS: 37 Lake Padgett Dr. Land O'Lakes FL 33539	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c): Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 89 to 2/16 19 89, that (I) (we) last saw the deceased alive on 2/15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Villamor S. Reyes DEGREE: M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): VILLAMOR S. REYES, M.D. — 22e. ADDRESS: 6501 Landover Rd. Cheverly, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 18, 1989	23c. NAME OF CEMETERY OR CREMATORY: St. Anne's	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Annapolis A.A. MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: Taylor Funeral Chapel, Annapolis, MD		25a. DATE REC'D. BY REGISTRAR: FEB 21 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Tindall	

025097 MAR-9 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05827
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Alexine	Windham	Haneline	February 26, 1989	2:48 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Dec. 2, 1909	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	Doctors Hospital	Secretary, Fire	Underwriters

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Hyattsville	YES ☒ NO ☐	3362 Toledo Terrace, Apt. J 20782

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	C.	Windham	Nellie	M.	Robey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	----------	492-16-0638	7000 Dartmouth Ave., 20781 Hazel W. Travers, College Park, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebrovascular

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 7 19 88 to Feb 26 19 89, that (I) (we) last saw the deceased alive on Feb 7 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
J. Richard Lilly	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	02-27-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. Richard Lilly	5804 Baltimore Ave., Hyattsville, Md. 20781

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	03-01-89	Ft. Lincoln Cemetery	Brentwood, P.G., Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS GASCH'S SONS FUNERAL HOME, P.A.	4739 Baltimore Ave., Hyattsville, Maryland	FEB 28 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023367 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 053228 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	KNOWN [X] ESTIMATED [ ]	MONTH	DAY	YEAR	2b. HOUR		
	Anna	MARIE	Hanold			1/26		1989			M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Female	White	Jul. 8, 1912	76 YRS.						1/26		1989	7:50 P. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [XX] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH									
WASHINGTON, D.C.	USA		Prince George's County MD.									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY									
Mt. Rainier	4511 Russell Avenue	HOUSEWIFE										

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince George's	Mt. Rainier	YES [ ] NO [ ]	4511 Russell Avenue 20712

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
DOMINIC		COLAVECCHIO	MARIA		DeMANA

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		577-07-3003	COUSIN ANGELA ERRIGO	9109 LeVELLE DR. CHEVY CHASE, MD 20815

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
None		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
		None

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 1/27/89

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	JAN 30, 1989	FORT LINCOLN CEMETERY	BRENTWOOD	PRINCE GEORGES	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	JAN 30 89	Julia Davidson-Randall

TO MEDICAL EXAMINER: THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024193 FEB 29 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053229
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Harvey	W.	Hargette	Feb. 16, 1989	2:05 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	June 16, 1912	76 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
North Carolina	U.S.A.		Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Clinton	Southern Maryland Hospital Cntr.	Boilermaker	Plumming

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr.George's	Camp Springs	YES ☐ NO ☒	5011 Sharon Rd. 20748

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Hiram	H.	Hargette	Daisy		Freeman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	n/a	237-14-4614	wife: Myrtle W. Hargette	same as 13 a-e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Obstructive Lung Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~this hospital~~ attended the deceased from 1/31, 19 89, to 2/16, 19 89, that (I) ~~saw~~ last saw the deceased alive on 2/16, 19 89, and that in (my) ~~our~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~saw~~ did not view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED Feb. 17, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis V. Kaufman

22e. ADDRESS 8926 Woodyard Rd. #602, Clinton, MD 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
burial	Feb. 21, 1989	Resurrection Cem	Clinton,	P.G.	MD

24. FUNERAL DIRECTOR (NAME) Lee Funeral Home, Inc. (ADDRESS) Old Alexander Ferry Rd., Clinton, MD 20735

25a. DATE REC'D. BY REGISTRAR FEB 23 1989

25b. REGISTRAR'S SIGNATURE Dawn Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then [illegible] and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4) 6633

024799 MAR -7 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005830

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then give remove certificate to person with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dorothy	MIDDLE: Louise	LAST: Harmon	2a. DATE OF DEATH MONTH DAY YEAR: February 20, 1989	2b. HOUR: 4:30 a.m.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 10, 1921	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.	
10. CITY OR TOWN OF DEATH: Bladensburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): 4105 51st Street, #103	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: Private Industry	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Bladensburg	YES [X] NO [ ]	4105 51st Street, #103 20710

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Albert / / Zendgraf	Gertrude / / Bosewell	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		217-22-1433	(Husband) 4105 51st Street, #103 Henry L. Harmon, Sr. Bladensburg, Md. 20710

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): head and neck cancer

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART II.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb, 1989 to Feb 20 1989, that (I) (we) last saw the deceased alive on Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Martin D. Weltz, M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Martin D. Weltz, M.D.	7525 Greenway Ctr. Dr. Greenbelt, Md. 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	02/20/89	Metropolitan Crematory	Alexandria / Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 BAltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR: FEB 21 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024943 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR STATE REGISTRAR
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 0 5 8 3 1

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Kermit Pierceson Harrod				2a. DATE KNOWN OF DEATH XX ESTIMATED ☐ MONTH DAY YEAR	2-23-19 89	2b. HOUR M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
MALE	BLACK	June 20, 1918	70 YRS.			2-23-19 89	8:05P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.		Prince Georges County MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Cottage City	4142 Bunker Hill Road	Retired	Government				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
MD.	Prince Georges	Cottage City		4142 Bunker Hill Road 20722

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Thomas Edward Harrod	Addie Nicholas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No / N/A	216-12-4534	Alma Dickerson	1648 Ft. Dupont St., S.E. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Contact shotgun wound of chest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Status Post laryngectomy due to Carcinoma of larynx

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	2-23-89	Self inflicted

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	home	4142 Bunker Hill Road, Cottage City, Prince Georges County, MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle Jr. M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-24-89

VC EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	March 2, 1989	Harmony Memorial Park	Landover, Maryland

24. NAME AND ADDRESS OF FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John T. Stewart, III 4001 Benning Rd., N.E. Stewart Funeral Home Wash. D.C.	MAR 01 '89	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 24M BP

5

DHMH - 17 (VR A1S ME (5))

024103 FEB 2 1 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05832
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Mildred	Ursula	HATCHER	February 14, 1989	11:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
Female	White	Nov. 22, 1893	95 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	AMI Doctors' Hospital of PG County	Housewife	Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Calvert	Broomes Isl.	YES ☐ NO ☒	Box 95, 20615

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
James Shipley	Mary Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	212-74-5769	Mary Ritchie (daughter)	10521 Walter Thomp. Vienna, Va. 22180

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Pulmonary Edema and Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Colon

DUE TO, OR AS A CONSEQUENCE OF (c) Septicemia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-31, 19 89, to 2-14, 19 89, that (I) (we) last saw the deceased alive on 2-14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Raleigh Arory MD		☐ ☒ ☐	2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Raleigh Arory, M.D.	14300 Gallant Fox La. Suite 222 Bowie, Md. 20715

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-18-1989	Broomes Island Cem.	Broomes Island, Calvert, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donald V. Borgwardt, 4405 Broomes Isl Rd; Port Republic, Md. 20676	FEB 17 1989	Gina Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or otherwise.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

22597 FEB 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005833

1. DECEASED NAME (TYPE OR PRINT)	FIRST Louise	MIDDLE Agnes	LAST Hatton					2a. DATE KNOWN OF DEATH ☑ ESTIMATED ☐	MONTH 2	DAY 2	YEAR 19 89	2b. HOUR M
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH 10	DAY 06	YEAR 19	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH 2	DAY 2	YEAR 19 89	2d. HOUR 9:40 M
Female	White														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Clinton, Md.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George's MD.								
10. CITY OR TOWN OF DEATH	Camp Springs	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Malcolm Grow Hospital AAFB	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Dietitian	12b. KIND OF BUSINESS OR INDUSTRY	PG Schools								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	P. G.	13c. CITY OR TOWN	Ft. Washington	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS	3819 Lumar Drive 20744							
14. FATHER'S NAME FIRST	Benjamin	MIDDLE		LAST	Marshall	15. MOTHER'S MAIDEN NAME FIRST	Viola	MIDDLE		LAST	Walker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	N/A	16b. SOCIAL SECURITY NO.	216-40-7113	17. INFORMANT	Russell L. Hatton	ADDRESS	Same as 13 A-E						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Severe rheumatoid arthritis with complications

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Fever ? etiology, joint replacements, arteriosclerosis, disability Quadriplegic

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2-3-89

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	02/06/89	Washington National Cem	Suitland	Prince Geo.	Md.

24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6633 Old Alexander Ferry Rd Clinton, Md 20735

25a. DATE REC'D. BY REGISTRAR FEB 09 1989

25b. REGISTRAR'S SIGNATURE Julia Gordon-Reuben

TO MEDICAL EXAMINER: HISTORY OF PHYSICIAN SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE BY WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5)

23042 FEB 17 8

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005834

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
CHARLES LEE HAWKINS			February 12, 1989	12:25 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
Male	Black	Jan. 19, 1919	70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH	
D.C.	U.S.A.		Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	AMI Doctors' Hosp. of Pr. Geo. Co.		Binder Oper.	U.S.Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	P.G.	Landover	YES [X] NO [ ]	3528 Brightseat Rd. 20785

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
William Hawkins	Ivy Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	578-14-4300	Victoria Hawkins-Same as # 9 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary collapse + arrest	5 min
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardiopathy	2-3 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Renal failure	4 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 1-4- 1989 to 2-12 1989, that (I) (we) last saw the deceased alive on 2/12 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	Feb. 13, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Ronald P. Hairston, M.D.	6910 Columbia Pk. Rd., Landover, Md.

23a. BURIAL, CREMATION, REMOVAL (CIRCLE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
	2/16/89	HARMONY MEM. PK.	LANDOVER, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E.	FEB 15 1989	[signature]

BP.

DHMH - 16 50M 1/81 (VRA 15, 4)

0230245 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053835
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	WILLIAM THOMAS HELM	2a. DATE OF DEATH MONTH DAY YEAR	February 1, 1989
		2b. HOUR	7:00 A M
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Oct. 3, 1912	6. AGE (IN YEARS LAST BIRTHDAY)	76 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Virginia	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George's MD.
10. CITY OR TOWN OF DEATH	Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12606 Silverbirch Lane
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Civil Engineer	12b. KIND OF BUSINESS OR INDUSTRY	Dept. of Def.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	PG	Laurel	YES [X] NO [ ]	12606 Silverbirch Ln., 20708

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Edward Helm	Eva Curtis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	----------	577-05-9310	Grace S. Helm, Same as Line #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Prostate Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 years
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I **certify** that (I) (this hospital) attended the deceased from July, 19 81, to January, 19 89, that (I) (we) last saw the deceased alive on ____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Nancy A Dawson	MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Nancy Dawson	6825 16th Street, N.W., Wash. DC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-03-89	Ft. Lincoln Cemetery	Brentwood, P.G., Maryland

24a. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland	FEB 9 89	

BP____

DHMH - 16 50M 4/82
(VRA 15, 4)

024970 MAR -8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05836
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the remaining sorbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Thomas	MIDDLE: C.	LAST: Henchcliffe	2a. DATE OF DEATH MONTH: 2	DAY: 23	YEAR: 89
2b. HOUR: 8-10 P.M.					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 11	DAY: 07	YEAR: 14	6. AGE (IN YEARS LAST BIRTHDAY): ~~77~~ 74 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5725 29th Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Operating Eng.	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: Hyattsville	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 5725 29th Avenue	20782
14. FATHER'S NAME FIRST: James	MIDDLE	LAST: Henchcliffe	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: Elizabeth	LAST: Price
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 216-09-3245	17. INFORMANT: Miriam Henchcliffe	ADDRESS: 5725 29th Avenue Hyattsville, MD 20782	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Oat Cell Carcinoma Lung
DUE TO, OR AS A CONSEQUENCE OF (c): Exhaustion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8-1-1988 to 2-23-1989, that (I) (we) last saw the deceased alive on 2-23-1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/24/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): G. M. DIN, M.D.	22e. ADDRESS: 6510 Kenilworth Ave Riverdale M.D. 20737		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/27/89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN: Brentwood	COUNTY: PG STATE: Maryland
24. FUNERAL DIRECTOR (NAME AND ADDRESS): Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781	25. DATE REC'D. BY REGISTRAR: FEB 28 '89	26. REGISTRAR'S SIGNATURE: Julia Davidson-Pendarvis		

BP____

DHMH - 16 50M 1/81 (VRA 15-4)

(10) IVA

Items 18a thru 22a per M.E. Film G650 4/10/89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0239135 FEB 28 89

FOR 1 - STATE REGISTRAR

REG. NO. 89 005837

DECEASED NAME (TYPE OR PRINT): FIRST Benny MIDDLE Rogers LAST Hill

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 2 DAY 8 YEAR 1989 — 2b. HOUR

3. SEX: MALE — 4. RACE: BLACK — 5. DATE OF BIRTH: JULY 15 1965 — 6. AGE (IN YEARS LAST BIRTHDAY): 23 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: 2-8-1989 — 2d. HOUR: 7:29 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.

10. CITY OR TOWN OF DEATH: Cheverly

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABORER

12b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: M.D. — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: LANDOVER — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 7757 NORMANDY ROAD 20785

14. FATHER'S NAME: FIRST BENNY R. MIDDLE LAST HILL SR.

15. MOTHER'S MAIDEN NAME: FIRST PEARLINE MIDDLE LAST EUERBE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 212-90-9650

17. INFORMANT ADDRESS: 7757 NORMANDY ROAD PEARLIE HILL LANDOVER MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cocaine abuse
Conditions, if any, which gave rise to immediate cause (a) stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. 2/8 MONTH DAY YEAR 1989 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Unknown

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): In auto — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: Prince Georges Co. Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X].

ACTUAL SIGNATURE: _____ M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 2-9-89

VC EXAMINER'S NAME (TYPE OR PRINT): James Kaplan,M.D. — ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 2-14-89 — 23c. NAME OF CEMETERY OR CREMATORY: HARMONY CEMETERY — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: LANDOVER P.G. M.D.

24. FUNERAL DIRECTOR NAME / ADDRESS: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON D.C. 20019

25a. DATE REC'D. BY REGISTRAR: FEB 23 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M — BP 390 — DHMH - 17 (VR A15 ME (5))

.D.

BENNY R.

NO

FANDOVER

023000 FEB 16 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053383 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Catherine HILL			2a. DATE OF DEATH MONTH DAY YEAR: February 4, 1989	2b. HOUR: 12:45PM
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: May 23, 1921	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.	
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctors Of Lanham		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Practical Nurse	12b. KIND OF BUSINESS OR INDUSTRY: Ret.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. Geo.	Land. Hills	YES X NO ☐	3902 71st. Ave. 20784

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
David Jackson	Ethel Helm		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	**(IF YES, GIVE WAR OR DATES)**	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT** / **ADDRESS**
No		577-32-8500	William Smith Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

(IMMEDIATE CAUSE (a)) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF: (b) severe Pulmonary Fibrosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF: (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary artery disease - Recent myocardial infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO XX	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/27 19 89 to 2/4 19 89, that (I) (we) last saw the deceased alive on 2/4 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Riad Dakhoe (M.D.)	ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	**22e. ADDRESS**	
Riad Dakheel	14300 Gallant Fox Ln. Bowie 20715	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/10/89	Cedar Hill Cem.	Hopewell Township, N.J.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wesley Funeral Home 126 N. Burlington Rd. Bridgeton, N.J.	FEB 9 '89	Gloria Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05839
REG. NO.

02445 MAR 289

1. DECEASED NAME (TYPE OR PRINT) — FIRST: George, MIDDLE: R., LAST: Hill
2a. DATE OF DEATH — MONTH: 02, DAY: 22, YEAR: 89
2b. HOUR: 1:15 PM
3. SEX: Male
4. RACE: Black
5. DATE OF BIRTH — MONTH: Sept., DAY: 31, YEAR: 1917
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.
10. CITY OR TOWN OF DEATH: Beltsville
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel/Beltsville Hosp
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): GROOM
12b. KIND OF BUSINESS OR INDUSTRY: RACE TRACK

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Pr. Geo
13c. CITY OR TOWN: Laurel
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS / ZIP CODE: 100 9½ St # 101 20707

14. FATHER'S NAME — FIRST: Floyd, MIDDLE: Hill, LAST:
15. MOTHER'S MAIDEN NAME — FIRST: Kate, MIDDLE: Spidding, LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 224-22-1944
17. INFORMANT — ADDRESS: Ethel Mae Hill (Wife) Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WKS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): CHRONIC OBSTRUCTIVE LUNG DISEASE — YRS
DUE TO, OR AS A CONSEQUENCE OF (c): TOBACCO ADDICTION — YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
D.I.C., HEPATIC FAILURE, HYPOGLYCEMIA, HYPERTENSION

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 2/9 19 89 to 2/22 19 89, that ~~I~~ (we) last saw the deceased alive on 2/22 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ did (did not) view the body after death.
22b. SIGNATURE: R. Magin — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/22/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): R. MAGIN
22e. ADDRESS: LAUREL, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-27-89
23c. NAME OF CEMETERY OR CREMATORY: Md. Nat'l Mem. Park
23d. LOCATION — CITY OR TOWN, COUNTY, STATE: Laurel, Pr. Geo., MD
24. FUNERAL DIRECTOR — NAME, ADDRESS: George R. Snowden Rockville, MD 20850
25a. DATE REC'D. BY REGISTRAR: FEB 27 1989
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024790 MAR 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005840

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Murray	MIDDLE: Russell	LAST: Holladay	2a. DATE OF DEATH KNOWN ☑ / ESTIMATED ☐	MONTH: 2	DAY: 13	YEAR: 19 89
2b. HOUR							
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: July 25 1919	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.	IF UNDER 1 YR. MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN:
2c. DATE PRONOUNCED DEAD	MONTH: 2	DAY: 13	YEAR: 19 89	2d. HOUR: 9:15 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.				
10. CITY OR TOWN OF DEATH: Capitol Hghts	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4305 Byers Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Service Stat.				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: P.G.	13c. CITY OR TOWN: Capitol Hghts	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 4305 Byers Street 20743			
14. FATHER'S NAME: FIRST John	MIDDLE	LAST: Holladay	15. MOTHER'S MAIDEN NAME: FIRST Cloey	MIDDLE	LAST: O'Neale		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 229 16 3940	17. INFORMANT ADDRESS: Helen Holladay/wife/same as #13				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-13-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb 16 1989	23c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove Cemetery	23d. LOCATION CITY OR TOWN: Herndon	COUNTY / STATE: Virginia
24. FUNERAL DIRECTOR NAME / ADDRESS: Robert E Wilhelm Funeral Home Suitland MD	25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pondexe		

022300 FEB 10 00

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 005341

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. SEE INSTRUCTIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Henry	MIDDLE:	LAST: Houston Sr.	2a. DATE KNOWN OF DEATH / ESTIMATED	MONTH: 2/6	DAY / YEAR: 19 89	2b. HOUR: M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH (MONTH DAY YEAR): Dec. 26, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: 2/6 19 89	2d. HOUR: 9:00 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Arkansas	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.				
10. CITY OR TOWN OF DEATH: Hyattsville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5918 Rosedale Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Minister	12b. KIND OF BUSINESS OR INDUSTRY: Religion				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: D. C.	13b. COUNTY	13c. CITY OR TOWN: Washington, D.C.	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 4900 - 9th Street, N. W.			
14. FATHER'S NAME FIRST: John	MIDDLE	LAST: Houston	15. MOTHER'S MAIDEN NAME FIRST: Jennie	MIDDLE: Dykes	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-01-0183	17. INFORMANT ADDRESS: Mrs. Emmie Houston/wife/same				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial disease
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): chronic myocardial disease.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): None
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: John S. Rogers M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2/6/89

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS: 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-11-89	23c. NAME OF CEMETERY OR CREMATORY: Maryland National	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Laurel, Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS: John T. Rhines Co., 3015 12th St. N.E., D.C. 20017		25a. DATE REC'D. BY REGISTRAR: FEB 08 1989	25b. REGISTRAR'S SIGNATURE: Julia Tenison-Randall	

07/84 25M BP
DHMH - 17
(VR A15 ME (5))

Items 18a, 22a per M.E. Film G650 4/7/89 CC

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005842

024422 MAR 23 89

1a. DECEASED NAME (TYPE OR PRINT): FIRST Delont MIDDLE O. LAST Howard

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 2 DAY 13 YEAR 89 — 2b. HOUR

3. SEX: Male — 4. RACE: Black — 5. DATE OF BIRTH: MONTH 10 DAY 25 YEAR 88 — 6. AGE (IN YEARS LAST BIRTHDAY): 0 YRS. — IF UNDER 1 YR. MONTHS 3 DAYS 12 — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 13 YEAR 89 — 2d. HOUR 6:41 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A infant — 12b. KIND OF BUSINESS OR INDUSTRY: N/A

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Prince George — 13c. CITY OR TOWN: Oxon Hill — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 5010 Manor Court 2219

14. FATHER'S NAME: FIRST David MIDDLE L LAST Howard — 15. MOTHER'S MAIDEN NAME: FIRST Bobbette MIDDLE LAST Outlaw

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: never applied — 17. INFORMANT: Bobbette O. Howard — ADDRESS: 5010 Manor Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sudden infant death syndrome
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED 2-14-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. — ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — 23b. DATE 2/16/89 — 23c. NAME OF CEMETERY OR CREMATORY Harmony — 23d. LOCATION CITY OR TOWN Landover PG COUNTY Maryland STATE

24. FUNERAL DIRECTOR NAME Velma W. Brock — ADDRESS 1661 Good Hope Rd SE Washington, DC — 25a. DATE REC'D. BY REGISTRAR FEB 27 1989 — 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M BP 375

DHMH - 17 (VR A15 ME (5))

024028 FEB 28 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR — REG. NO. 89 005343

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Pauline	MIDDLE: Lydia	LAST: HOWARD	2a. DATE OF DEATH MONTH DAY YEAR: 2/15/89	2b. HOUR: 1:30 AM	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: Dec 11 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George's Gen. Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife	12b. KIND OF BUSINESS OR INDUSTRY: -		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	PG	Upper Marl.	YES ☐ NO ☒	2110 Largo Rd/20772

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
George / Lauterbach	Alice / Lucas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	n/a	220509005	Alice Y. Robertson	1622 Paris Oaks Rd. Owings, MD 20736

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Cerebral Bleeding

DUE TO, OR AS A CONSEQUENCE OF (b): Multi System Faulures

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert J Gerecke MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ROBERT J GERECKE	4410 74th Ave Landover Hills, MD 20784

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-18-89	St Barnabas Church	Upper Marlboro PG MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rausch Funeral Home Owings MD	FEB 23 1989	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

025082 MAR -9 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

REG. NO. 89 053441

1. DECEASED NAME (TYPE OR PRINT): Edward Sterling HURD
2a. DATE OF DEATH: February 19, 1989
2b. HOUR: 8:36 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Feb. 17, 1906
6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
10. CITY OR TOWN OF DEATH: Lanham
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Doctor's Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Warehouse Supervisor
12b. KIND OF BUSINESS OR INDUSTRY: U.S. Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: P.G.
13c. CITY OR TOWN: Lanham
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 8002 Tiffany Lane 20706

14. FATHER'S NAME: Edward Hurd
15. MOTHER'S MAIDEN NAME: Nannie L. Fagg
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes-Army
(IF YES, GIVE WAR OR DATES): WWII
16b. SOCIAL SECURITY NO.: 577-09-5730
17. INFORMANT (Wife) 8002 Tiffany Lane
Olivia L. Hurd Lanham, Maryland 20706

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asystole
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypotension

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 17, 19 89, to Feb 19, 19 89, that (I) (we) last saw the deceased alive on Feb 19, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: David A. Brill MD
DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/20/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): David A. Brill MD
22e. ADDRESS: Doctor's Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 02/22/89
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland P.G. Maryland
24. FUNERAL DIRECTOR: Francis Gasch's Sons Funeral Home, P.A.
ADDRESS: 4739 BAltimore Avenue Hyattsville, Md. 20781
25a. DATE REC'D BY REGISTRAR: FEB 23 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

023173 FEB 17 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053845 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
STEVEN	J.	JACKSON	02	11	89	7 30A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	BLACK	05	08	53	35 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	United States		PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	Tele. Representative	Private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	PG	Landover	YES ☒ NO ☐	2111 Connecticut Avenue

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James		Exum	Delores		Harris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Korean	578-70-5683	Delores Brooks/2111 Connecticut Ave.	Landover, MD 20785

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS
DUE TO, OR AS A CONSEQUENCE OF
(b) ACQUIRED IMMUNE DEFICIENCY SYNDROME — MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I/this hospital) attended the deceased from 2/10 19 89 to 2/14 19 89, that (I/we) last saw (him/her) alive on 2/10 19 89, and that in (my/our) opinion death occurred on the date and hour and from the cause stated above. (He/She) did not/did) did not view the body after death.

22b. SIGNATURE — DEGREE MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 4/12/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) P SCHNEIDER MD

22e. ADDRESS 7500 Greenway Ctr Dr. Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	14 Feb 89	Cedar Hill Crematory	Suitland	PG	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
JB Jenkins FH/7474 Landover Rd.	Landover, MD	FEB 15 1989	Gloria Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024463 MAR 2 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 REG. NO. 058456

1. DECEASED NAME (TYPE OR PRINT): FIRST Doris MIDDLE J. LAST Johnson

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 23 YEAR 1989 — 2b. HOUR ___ M

3. SEX: Female — 4. RACE: Cauc. — 5. DATE OF BIRTH: MONTH April DAY 15 YEAR 1895 — 6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS. — IF UNDER 1 YR.: MONTHS ___ DAYS ___ — IF UNDER 24 HRS.: HOURS ___ MIN ___

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 23 YEAR 1989 — 2d. HOUR 7:30 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England

7b. CITIZEN OF WHAT COUNTRY? United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's Co. MD.

10. CITY OR TOWN OF DEATH: Clinton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): So. Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Prince George's — 13c. CITY OR TOWN: Clinton — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 6907 Dalmaitia Dr., 20735

14. FATHER'S NAME: FIRST Thomas MIDDLE LAST Jones

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST Broadbent

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 206-12-200.

17. INFORMANT: Raymond Johnson/Son — ADDRESS: 7011 Dower House Rd, Upper Marlboro, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (b): ___

DUE TO, OR AS A CONSEQUENCE OF (c): ___

8842

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Right humeral fracture

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR 5 A.M. P.M. ☑ MONTH 12 DAY 1 YEAR 1988 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Fell out of bed

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home — 21f. LOCATION STREET 9607 Dalmatia Drive CITY OR TOWN Clinton COUNTY Prince Geo. STATE Md

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-24-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez MD — ADDRESS: 5009 Raytown Ct. Ft. Geo. Md 20744

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 1989 March 1 — 23c. NAME OF CEMETERY OR CREMATORY: Cremation Specialist — 23d. LOCATION CITY OR TOWN: Media COUNTY STATE: Pennsylvania

24. FUNERAL DIRECTOR NAME AND ADDRESS: Cavanagh's Funeral Home, 6922 Woodland Ave, Philadelphia, PA 19142

25a. DATE REC'D. BY REGISTRAR: FEB 28 1989 — 25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM HM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17
(VR A15 ME (5))

024600 MAR 3 9

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO 05347

1. DECEASED NAME (TYPE OR PRINT): First Margaret; Middle Geraldine; Last Johnson

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ — Month 2/20 Day Year 19 89

2b. HOUR: M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH: Month Aug. Day 23 Year 1937

6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS.

IF UNDER 1 YR.: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN.

2c. DATE PRONOUNCED DEAD: Month 2/20 Day Year 19 89

2d. HOUR: 11:15 A. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.

10. CITY OR TOWN OF DEATH: Glenarden

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2916 Brightseat Road, #302

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince George's

13c. CITY OR TOWN: Glenarden

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 2916 Brightseat Road, #302 20706

14. FATHER'S NAME: First Norman; Middle; Last Brown

15. MOTHER'S MAIDEN NAME: First Bertha; Middle L.; Last Day

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-42-9943

17. INFORMANT: John W. Johnson-Same as # 13 above — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease

DUE TO, OR AS A CONSEQUENCE OF

(b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): None

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED 2/20/89

EXAMINER'S NAME (TYPE OR PRINT): John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (CIRCLE)

23b. DATE: 2/27/89

23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM. PARK

23d. LOCATION CITY OR TOWN: LANDOVER COUNTY: P.G. STATE: MD.

24 FUNERAL DIRECTOR NAME AND ADDRESS: H. S. WASHINGTON & SONS 4925 BUCHANAN ST. N.E.

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024921 MAR-8 07 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053843 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Theodore MIDDLE: Lafayette LAST: JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR: February 4, 1989 3:	2b. HOUR: 3:25P M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: October 6, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.	
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Doctor's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: New Carrollton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 5334 85th Avenue 20784
14. FATHER'S NAME FIRST: Harry MIDDLE LAST: Johnson			15. MOTHER'S MAIDEN NAME FIRST: Isabelle MIDDLE LAST: Edwards	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Army	16b. SOCIAL SECURITY NO.: 577-40-5856	17. INFORMANT: Barbara Burris	ADDRESS: 5334 85th Avenue New Carrollton, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension, CHF
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 11, 1989	23c. NAME OF CEMETERY OR CREMATORY: Maplewood Cemetery	23d. LOCATION CITY OR TOWN: Greensboro COUNTY: N.C. STATE	
24a. FUNERAL DIRECTOR NAME: Stewart Funeral Home	ADDRESS: 4001 Benning Road, Washington, D.C.	24b. DATE REC'D. BY REGISTRAR: FEB 10 '89	25b. REGISTRAR'S SIGNATURE: [signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023039 FEB 17 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053849 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Verbena / S. / JOhnson	2a. DATE OF DEATH — MONTH DAY YEAR	January 31, 1989	2b. HOUR	20:20 M
3. SEX	Female	4. RACE	Black	5. DATE OF BIRTH — MONTH DAY YEAR	Oct. 16, 1901
6. AGE (IN YEARS LAST BIRTHDAY)	87 YRS.	IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Va.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George's MD.				
10. CITY OR TOWN OF DEATH	Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Leland Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Domestic
12b. KIND OF BUSINESS OR INDUSTRY	Cleaning				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	P.G.	13c. CITY OR TOWN	Adelphi
13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS	3101 Gumwood Dr. 20783		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Thornton / Smith	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Mary / Robinson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO	578-48-4483
17. INFORMANT — ADDRESS	Moses Johnson, Jr. - Same as # 13				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmanary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-12, 19 89, to 1-31, 19 89, that (I) (we) last saw the deceased alive on 1-31, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Rerathy Murthy	DEGREE MBBS ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/1/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	REVATHY MURTHY	22e. ADDRESS	6130, LANDOVER RD, LANDOVER MD

23a. BURIAL (CREMATION, REMOVAL)	23b. DATE 2/4/89	23c. NAME OF CEMETERY OR CREMATORY	LITTLE ZION BAPT. CH. CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: GREENVILLE, VA.
24. FUNERAL DIRECTOR NAME	N.S. WASHINGTON & SONS	ADDRESS	4925 Burroughs Ave.	25a. DATE REC'D. BY REGISTRAR: FEB 15 1989
25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall			

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024982 MAR 3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05850

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	First: Dale (Dale)	Middle: Dwain	Last: Jones (Jones)	2a. DATE KNOWN OF DEATH ☑ / ESTIMATED ☐	Month: 2 Day: 8 Year: 1989
2b. HOUR OF DEATH	M				
3. SEX	4. RACE	5. DATE OF BIRTH (Month, Day, Year)	6. AGE (In years last birthday)	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min
Male	White	12-18-35	53 YRS.		
2c. DATE PRONOUNCED DEAD	Month: 2 Day: 8 Year: 1989	2d. HOUR	1940 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Michigan	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.
10. CITY OR TOWN OF DEATH	Lanham	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Doctors Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Accountant
12b. KIND OF BUSINESS OR INDUSTRY	Hospital				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Lanham	YES ☐ NO ☒	6917 Heidelburg Road, 20706

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
LLoyd / / Jones	Mary / / Merritt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	peacetime	368-34-5531	Katherine M. Jones,	Same as Line #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Obstructive pulmonary disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

~~DUE TO, OR AS A CONSEQUENCE OF~~

(b) with hemoptysis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-9-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-11-89	Ft. Lincoln Cemetery	Brentwood, P.G., Maryland

24. FUNERAL DIRECTOR (NAME AND ADDRESS)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland	FEB 17 '89	Julia Davidson-Randall

15

IVA

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

022781 FEB 15 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05851 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROSE MIDDLE: AKA WILLS LAST: JONES				2a. DATE OF DEATH MONTH DAY YEAR: 02 04 89	2b. HOUR: 1:35 PM
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: September 26, 1933	6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. United States	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XXX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired U.S. Gov't Employee	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Temple Hill	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS / ZIP CODE: 2411 Fairlawn Street 20748	
14. FATHER'S NAME FIRST MIDDLE LAST: Robert Douglas Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Lula Mae Jackson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-32-3958	17. INFORMANT ADDRESS: Gary Jones Husband Same as 9D.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Carcinoma to Lung, Bones
DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of colon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, I.D.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-24, 1989, to 2-4, 1989, that (I) (we) last saw the deceased alive on 2/4, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Thos H Cleary Jr. DEGREE: MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-5-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 09 Jan 89	23c. NAME OF CEMETERY OR CREMATORY: Lincoln Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, Maryland	
24. FUNERAL DIRECTOR NAME / ADDRESS: Frazier's Funeral Home 389 Rhode Island AVe.		25a. DATE REC'D. BY REGISTRAR: FEB 10 1989	25b. REGISTRAR'S SIGNATURE: Julia Davison-Lindsay	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

023964 FEB 20 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR — REG. NO. 89 005852

1. DECEASED NAME (TYPE OR PRINT): FIRST Vanessa MIDDLE J. LAST Jones
2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 5 YEAR 1989 — 2b. HOUR
3. SEX: Female — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH MARCH DAY 23 YEAR 56 — 6. AGE (IN YEARS, LAST BIRTHDAY): 32 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN
2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 5 YEAR 1989 — 2d. HOUR 1107 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE Co. MD.
10. CITY OR TOWN OF DEATH: CAMP SPRING — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ANDREWS A.F. FORCE HOSP. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SECRETARY — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md. — 13b. COUNTY: KENT — 13c. CITY OR TOWN: WORTON — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: R.F.D 21678

14. FATHER'S NAME: FIRST Rodney MIDDLE LAST JONES — 15. MOTHER'S MAIDEN NAME: FIRST JANICE MIDDLE LAST G.Gilbert
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): — 16b. SOCIAL SECURITY NO.: 218-70-4659 — 17. INFORMANT: ADDRESS: Miss FRANCES Gilbert R.F.D WORTON, MD. 21620

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatoid heart disease with valve — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF: Replacement
~~DUE TO, OR AS A CONSEQUENCE OF~~
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-5-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 2-11-1989 — 23c. NAME OF CEMETERY OR CREMATORY: U.N. CEM. — 23d. LOCATION CITY OR TOWN: Worton COUNTY: Kent STATE: Md.

24. FUNERAL DIRECTOR NAME: Kenneth Wolfe ADDRESS: Chestertown — 25a. DATE RECD. BY REGISTRAR: FEB 15 89 — 25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17
(VR A15 ME (5))

022688 FEB 14 09 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005353 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ~~Fred~~ William MIDDLE:	LAST: Jones	2a. DATE OF DEATH MONTH: 2 DAY: 8 YEAR: 89	2b. HOUR: 8P M	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: MAR DAY: 22 YEAR: 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ~~P.G.~~ Montgomery Co MD.	
10. CITY OR TOWN OF DEATH: TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON ADVESNTIST HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FORMAN	12b. KIND OF BUSINESS OR INDUSTRY: P.G. SCHOOLS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: M.D.	13b. COUNTY: P.G.	13c. CITY OR TOWN: UPPER MARLBORO	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 8505 WESTPHALIA ROAD 20772
14. FATHER'S NAME FIRST: BENNY MIDDLE: LAST: JONES		15. MOTHER'S MAIDEN NAME FIRST: MAIMI MIDDLE: LAST: WRIGHT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-12-3223	17. INFORMANT ADDRESS: 8505 WESTPHALIA ROAD	DOROTHY LLOYD UPPER MARLBORO MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): metastatic prostate carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: YEARS
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): senile dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (the hospital) attended the deceased from Oct, 19 88, to 2/8, 19 89, that (I) (we) last saw the deceased alive on 2/2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Peter M. Schissler, M.D.

22e. ADDRESS: 7500 Greenway Center Drive #430 Greenbelt, Maryland 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-14-89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY CEMETERY	23d. LOCATION CITY OR TOWN: LANDOVER	COUNTY: P.G. STATE: MARYLAND
24. FUNERAL DIRECTOR NAME: ROLLINS FUNERAL HOME, INC. ADDRESS: 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019		25a. DATE RECD. BY REGISTRAR: FEB 10 1989	25b. REGISTRAR'S SIGNATURE: Julia Dendon-Landeau	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

89 053541
REG. NO.

023300 FEB 21 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER NOTIFIED - WILL RELEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Percy	MIDDLE: William	LAST: Kaye KAYE	2a. DATE OF DEATH MONTH DAY YEAR: 2 7 89	2b. HOUR: 845 P M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 07 12 94	6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS. HOURS MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Rhode Island	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES Co MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): So. MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Private Interpri Textile Co.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P. G.	Clinton	YES ☐ NO ☒	5704 Ramblewood Ave. 20735

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William		Kaye	Martha		Mallinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1918-1919	039-03-8138	Kenneth W. Kaye	Same as 13 A-E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	12 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Bronchopneumonia	3 days
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease; Renal insufficiency

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from March, 19 87, to Feb 7, 19 89, that (I) (we) last saw the deceased alive on Feb 7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
J. Sanford Young	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. Sanford Young MD	11701 Livingston Rd #101 Ft. Wash. Md 20744

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	STATE
Cremation	02/08/89	Lee's Crematory	Clinton Prince Geo.	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc.	6613 Old Alexander Ferry Road Clinton, Md 20735	FEB 16 1989	Gicha Davidson-Randall

025091 MAR-9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005855
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Bounthong	MIDDLE	LAST: KHAMMOUNE	2a. DATE OF DEATH MONTH DAY YEAR: 2-21-89	2b. HOUR: 4 50 PM
3. SEX: M	4. RACE: Lao	5. DATE OF BIRTH MONTH DAY YEAR: 5 4 26	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Laos	7b. CITIZEN OF WHAT COUNTRY?: Laos	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH: Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sheet Metal	12b. KIND OF BUSINESS OR INDUSTRY: R.D.Bean Inc.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	P.G.	Hyattsville	YES ☒ NO ☐	2010 Oglethorpe St. Apt. 304 20782

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
UNKNOWN	UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	**16b. IF YES, GIVE WAR OR DATES**	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT / ADDRESS**
NO	-------	577-11-0762	Thongdy Yotin Same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): hepatorenal failure
DUE TO, OR AS A CONSEQUENCE OF: (b): sepsis from hepatoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF: (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): cirrhosis Hepatis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 1/3 19 89 to 2/21 19 89, that (I) (we) last saw the deceased alive on 2/24 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Lewis Dennis M.D.	6201 Greenbelt Rd. College Park MD. 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/25/89	Chambers Crematory	Riverdale P.G. MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W.W.Chambers Co. Inc.	5801 Cleveland Ave. Riverdale Md.20737	FEB 24 '89	Julia Davidson Rondeau

BP

DHMH - 1650M 1/81 (VRA 15, 4)

021958 FEB 8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005856
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: JOHN	MIDDLE: KING	LAST: JR	2a. DATE OF DEATH: MONTH 02	DAY 02	YEAR 89	2b. HOUR 5.30A M
3. SEX: MALE	4. RACE: Black	5. DATE OF BIRTH: MONTH 7	DAY 26	YEAR 35	6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Auto Shop	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: P.G.	13c. CITY OR TOWN: ADELPHI	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 1813 KEOKEE ST. 20783			
14. FATHER'S NAME: FIRST JOHN MIDDLE KING LAST SR				15. MOTHER'S MAIDEN NAME: FIRST FANNIE MIDDLE LEE LAST DIMPSEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: N/A		17. INFORMANT: Janice KING (WIFE)	ADDRESS: 1813 Keokee ST		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA, PNEUMOCOCCAL AND MENINGITIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS
DUE TO, OR AS A CONSEQUENCE OF (b): ALCOHOLISM — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I/this hospital) attended the deceased from 2/6 19 89 to 2/2 19 89, that (I/we) last saw the deceased alive on 2/4 19 89, and that (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/8/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): P. CHANDLER MD
22e. ADDRESS: 7500 Greenway Cir N Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-11-89	23c. NAME OF CEMETERY OR CREMATORY: Red Hill C.H. Cem.	23d. LOCATION: CITY OR TOWN: Whitaker	COUNTY: EDGECOMB	STATE: N.C
24. FUNERAL DIRECTOR: NAME: MODERN Funeral Home	ADDRESS: 3821-14th ST. N.W.	25a. DATE REC'D. BY REGISTRAR: FEB 6 1989	25b. REGISTRAR'S SIGNATURE: [signature]		

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

023729 FEB 26 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 058577

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Eric	MIDDLE: Alphonso	LAST: Kirk	2a. DATE KNOWN OF DEATH / ESTIMATED	MONTH: 2	DAY: 2	YEAR: 19 89	2b. HOUR: M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH (MONTH DAY YEAR): March 4,1970	6. AGE (IN YEARS LAST BIRTHDAY): 18 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH: 2	DAY: 2	YEAR: 19 89	2d. HOUR: 6:00P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington,D.C.	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.							
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auto Supply Delivery Driver	12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: District Heights	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 2134 Roslyn Avenue, (20748)						
14. FATHER'S NAME: FIRST Willie	MIDDLE Lewis	LAST Melson Sr.	15. MOTHER'S MAIDEN NAME: FIRST Vivian	MIDDLE Elaine	LAST Kirk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-04-8580	17. INFORMANT ADDRESS: 4501 South Capitol Street,S.W. Vivian E.Kirk(mother) Apt.301;Wash.D.C.								

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 2 gunshot wounds to head
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 12:15AM 1-30-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject shot
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): street	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 8104 Richard Drive, Forestville, Prince Geo. County, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐,

ACTUAL SIGNATURE: Chas P. Kokes M.D. TITLE (SPECIFY): Acting Deputy Cheif MEDICAL EXAMINER DATE SIGNED: 2-2-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes,M.D; ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb.08,1989	Lincoln Memorial Cemetery	Suitland,P.G.Co.,Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LATNEY'S FUNERAL HOME 3831 Georgia Avenue,N.W.;Washington,D.C. 20011	FEB 22 1989	Gisela Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024291 FEB 23 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 055358 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
John	A.	Komsa Jr.	February 23 1989	7:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	July 30, 1934	54 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
New Lersey	United States		Prince George's County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Bowie	8401 Chesnut Avenue		Production Planner	Printing	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P.G.	Bowie	YES [X] NO [ ]	8401 Chesnut Avenue/20715

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	A.	Komsa	Tillie Amelia		Kalemba

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		577-46-2901	Joanna Irene Komsa,	Same as # 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cholangiocarcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from January 20, 19 89, to February 23, 19 89, that (I) (we) last saw the deceased alive on February 15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Jeffrey M. Crane	MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JEFFREY M. CRANE	14500 Physicians Lane #212 Rockville, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 27, 1989	Resurrection Cemetery	Clinton, P.G., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	MAR 1 - 1989	Gloria Davidson-Randall

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

024067 FEB 23 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05859
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Name (if any) is required by law. Item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Frieda; MIDDLE: ; LAST: Kornitzer			2a. DATE OF DEATH — MONTH: Feb; DAY: 19; YEAR: 1989	2b. HOUR: 9 50 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH — MONTH: 10; DAY: 27; YEAR: 05	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Lithuania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.	
10. CITY OR TOWN OF DEATH: Largo Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Manor Care - Largo		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P.G.	Laurel	YES ☒ NO ☐	12956 Claxton Drive (20708)

14. FATHER'S NAME — FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME — FIRST	MIDDLE	LAST
Mordechai		Schindler	(Unknown)		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	--------	178-30-9415	Rena Friedman;Daughter;	12956 Claxton Drive; Laurel, Md. 20708

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	
DUE TO, OR AS A CONSEQUENCE OF (b)	Aspiration	
DUE TO, OR AS A CONSEQUENCE OF (c)	Esophageal Cancer	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 912

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/P Myocardial Infarction; S/P Cerebrovascular Accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from June 23 1988, to Feb 19, 1989, that (I) (we) last saw the deceased alive on Feb 7 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Stuart Turkewitz	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stuart Turkewitz	7500 Greenway Cntr. Dr. Greenbelt, Md. 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN; COUNTY; STATE
Burial	2/21/89	B'Nai Israel Cong. Cemetery;	Oxon Hill, P.G.; MD

24. FUNERAL DIRECTOR — NAME; ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	FEB 23 1989	Julia Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

021938 FEB 3 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 053860
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: THELMA	MIDDLE: B.	LAST: KNAPP	2a. DATE OF DEATH MONTH DAY YEAR: 2/5/89	2b. HOUR: 5.45A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan 15 1910	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET NUMBER AND STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Ret. US Govt	12b. KIND OF BUSINESS OR INDUSTRY: IRS		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Pr. Georges	13c. CITY OR TOWN: Hyattsville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 6940 Greenvale Pkwy. 20784

14. FATHER'S NAME FIRST: Everett	MIDDLE	LAST: Bartlett	15. MOTHER'S MAIDEN NAME FIRST: Louella MIDDLE:	LAST: Tuttle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 579-48-8599	17. INFORMANT: Virginia Coppa-dau- ADDRESS: 12605 Summerwood Dr. Sil. Spr. Md. 20904

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebro Vascular Accident - Coma

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: History of CVA, history of myocardial infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-28, 19 89, to 2-5, 19 89, that (I) (we) last saw the deceased alive on 2-4 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Vicken Poochikian	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: Feb. 5, 1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT): VICKEN POOCHIKIAN, MD	22e. ADDRESS: 5632 Annapolis Rd Bladensburg, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-8-1989	23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Washington, DC	
24. FUNERAL DIRECTOR: Hines/Rinaldi Funeral Home ADDRESS: 11800 N.H. Ave., Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 6 1989	25b. REGISTRAR'S SIGNATURE: Glenna Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

023302 FEB 22 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005361
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Dorothy	MIDDLE: Margaret	LAST: Krakosky	2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☑ MONTH: 2 DAY: 10 YEAR: 89	2b. HOUR: M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: 10 DAY: 16 YEAR: 27	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YR. MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 10 YEAR: 89	2d. HOUR: 3:19 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.				
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary/Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Bd. Co. School Board				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P. G.	Upper Marlboro	YES ☐ NO ☒	10806 Tyrone Drive 20772

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Benjamin		King	Louise		Womersley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	579-32-7328	Ann Court	203 176th Ave. Redington Shores Fla 33708

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-10-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	02/14/89	Resurrection Cemetery	Clinton	Prince George's	Md.

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. ADDRESS: 6633 Old Alexander Ferry Rd Clinton, Md 20735

25a. DATE REC'D. BY REGISTRAR: FEB 16 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024304 FEB 2 1989

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05362
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Elizabeth, REBECCA Lacey	2a. DATE OF DEATH MONTH DAY YEAR	February 26, 1989
2b. HOUR	10;36 AM		
3. SEX	FEMALE	4. RACE	CAUC.
5. DATE OF BIRTH MONTH DAY YEAR	MAY 2, 1914	6. AGE (IN YEARS LAST BIRTHDAY)	74 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Prince, George's MD.
10. CITY OR TOWN OF DEATH	Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Leland Memorial
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	OFFICE MGR	12b. KIND OF BUSINESS OR INDUSTRY	LAUNDRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD.	13b. COUNTY	PR.GEO.
13c. CITY OR TOWN	COLLEGE PARK	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS	4711 BERWYN HOUSE RD. 20740		
14. FATHER'S NAME FIRST / MIDDLE / LAST	JOHN W. FINNELL	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	CLARA SANDS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	577-36-4925	17. INFORMANT	ELIZABETH A. DeLaVergne
ADDRESS	FAIRFAX STA. VA. 9825 S.PARK CIRCLE		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Multiple Myeloma.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-16- 19 89, to 2-26- 19 89, that (I) (we) last saw the deceased alive on 2-26- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M. Baigns — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-27-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. BAIGNS MD — 22e. ADDRESS: 3450 Fort Meade Rd Laurel, Md 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	3/1/89	WASHINGTON NATIONAL	SUITLAND, MD.

24. FUNERAL DIRECTOR: MURPHY FUNERAL HOME 4510 WILSON BLVD. ARLINGTON, VA

25a. DATE REC'D BY REGISTRAR: MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE: Judith Davison Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

Items18a,b,22a per M.E. FilmG650 4/7/89 CG

0245911 MAR-3 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005363

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Richard	Joseph	Lam

7a. DATE OF DEATH KNOWN ☐ ESTIMATED XX: MONTH 2 DAY 22 YEAR 89 — 2b. HOUR M

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 1 YR. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	7c. DATE PRONOUNCED DEAD (MONTH DAY YEAR)	7d. HOUR
Male	White	March 11, 57	31 YRS.					2-22-89	10:38 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Wash.D.C.	U.S.A.		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hyattsville	1900 Block Rivaton Street	NONE	NONE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS
NONE	NONE	NONE		NONE 99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JUSTIN	WILSON	LAM	BARBARA		ADAMS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	-------	219-74-2489	JOHN FITSPATRICK	5309 RIVERDALE RD. RIVERDALE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) FAtty liver

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic alcohol abuse

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-23-89

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

VC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
CREMATION	2-25-1989	CHAMBERS CREMATORY	RIVERDALE,	P.G.C.	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO.	RIVERDALE, Md. 20737	MAR 1 - 1989	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGES 1 AND 2 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP383

DHMH - 17 (VR A15 ME (5))

023159 FEB 17 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

89 055864 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b HOUR
SAMUEL	IRVING	LEAKE	FEBRUARY	5	89	704 P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	Sept. 17, 1919	69 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARITAL STATUS	9 BALTIMORE CITY OR COUNTY OF DEATH
Virginia	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Prince Georges MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Clinton	Southern Maryland Hosp. Ctr.	Carpenter	U. S. Gov't

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
D. C.		Washington	YES [X] NO [ ]	2816 31st St., SE, Wash., D.C. 20020

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel		Leake	Evie		Burke

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Yes	World War II	227-07-7235	wife Alberta Hall Leake	2816 31st St. SE, Wash., D.C. 20020

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Lt.L.L. Pneumonia witn Empyema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec. 78 to Feb.5th 88, that (I) (we) last saw the deceased alive on Feb. 5th 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Victor S. Chupkovich DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED Feb.6th,1988

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Victor S. Chupkovich,M.D.	9131 Piscataway Rd., Clinton,Md. 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / STATE
Removal	2-6-89	Fairview Cemetery	Culpeper, Culpeper Co., VA

24. FUNERAL DIRECTOR NAME / ADDRESS

25a. DATE REC'D. BY REGISTRAR: FEB 13 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1660M 7/84
(VRA 15, 4)

023574 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005865

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	MEETA /	/ Liiv	2a. DATE OF DEATH MONTH DAY YEAR: 2-15-1989
2b. HOUR	8:45A M		
3. SEX	FEMALE		
4. RACE	WHITE		
5. DATE OF BIRTH MONTH DAY YEAR	8 / 29 / 1919		
6. AGE (IN YEARS LAST BIRTHDAY)	69 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Estonia		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐			
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George MD.		
10. CITY OR TOWN OF DEATH	LAUREL		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	4805 Davron St., Laurel, Md.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Ret. Director		
12b. KIND OF BUSINESS OR INDUSTRY	YWCA		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	13c. CITY OR TOWN: Baltimore
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET ADDRESS	3200 Westfield Ave. 21214		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Adolf /	/ Vallner	
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Rosalie /	/ Hermann	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 148-26-5281
17. INFORMANT ADDRESS	Tiina Ets, 4805 Davron St., Laurel, Md. 20707		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Liver failure	~2 months
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic melanoma	~2 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from June 6 19 86 to February 15 19 89, that (I) (we) last saw the deceased alive on February 21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul Chang MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Paul Chang

22e. ADDRESS: 5601 Loch Raven Blvd, Baltimore, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-18-89	Parkwood	Balto., Md. 21239

24. FUNERAL DIRECTOR NAME / ADDRESS: LEONARD J. RUCK INC. 5305 HARFORD RD. BALT. 21214

25a. DATE REC'D. BY REGISTRAR: FEB 17 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

024465 MAR -2 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005866 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: GRACE Middle:	Last: Little	2a. DATE OF DEATH Month Day Year: 02-25-89	2b. HOUR: 1:13 PM		
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month Day Year: Jan. 9, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George County MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern M.d. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: Washington DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 1730 7th Street, N.W. #1009	
14. FATHER'S NAME First Middle Last: Unknown		15. MOTHER'S MAIDEN NAME First Middle Last: Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 231-01-0648	17. INFORMANT: Annie M. Calloway	ADDRESS: 1730 7th Street, N.W. Washington, D.C.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ASHD - Diabetes - Renal Failure - UTI - TIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/4 19 89 to 2/25 19 89 that (I) (we) last saw the deceased alive on 2/25 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Reza Mostafavi DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): REZA MOSTAFAVI — 22e. ADDRESS: 9235 26th Ave Md 20748

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 3/5/89	23c. NAME OF CEMETERY OR CREMATORY: Huntersville House of Prayer Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Huntersville, N.C.	
24. FUNERAL DIRECTOR NAME: Ives-Pearson Funeral Home ADDRESS: 2847 Wilson Blvd., Arlington, Va. 22201			25a. DATE REC'D. BY REGISTRAR: FEB 28 1989	25b. REGISTRAR'S SIGNATURE: Patricia Tuidson-Randall

BP 999999

DHMH - 1630M 1/81 (VRA 15, 4)

024788 MAR 7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005867 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Oree	MIDDLE: E.	LAST: Lott	2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ]	MONTH: 2-	DAY: 13-	YEAR: 19 89	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH Oct DAY 13 YEAR 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 2- DAY 13- YEAR 19 89		2d. HOUR: 3:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mississippi	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.					
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Federal Employee	12b. KIND OF BUSINESS OR INDUSTRY: USDA						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE: MD	13b. COUNTY: PG	13c. CITY OR TOWN: Hillcrest Hghts	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 4009 25th Ave 20748					
14. FATHER'S NAME: FIRST Wheeler MIDDLE LAST Lott				15. MOTHER'S MAIDEN NAME: FIRST Sally MIDDLE Jane LAST Wells					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 427 26 1343		17. INFORMANT ADDRESS: Evelyn Lott/wife/same as #13					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(a) IMMEDIATE CAUSE	Multiple injuries complicating Hypertensive arterios-	
DUE TO, OR AS A CONSEQUENCE OF	XXXXXXXXXXXXXXXX CLEROTIC CARDIOVASCULAR DISEASE	
(b) DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2-13-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): PEDESTRIAN STRUCK BY AUTO
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): STREET	21f. LOCATION STREET: Iverson Street at 25th Avenue, CITY OR TOWN: Prince Geoges County, COUNTY: Maryland STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Chas P. KOkes M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 2-13-89

vc EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb 18 1989	Ft Lincoln	Brentwood	PG	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert E Wilhelm Funeral Home	Suitland MD	FEB 17 '89	Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023038 FEB 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005868
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Henry	MIDDLE	LAST: Luster	2a. DATE OF DEATH MONTH DAY YEAR: February 8, 1989	2b. HOUR: 4:05A.M.	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: June 3, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Bowie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 12013 Maddox Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chauffer	12b. KIND OF BUSINESS OR INDUSTRY: U.S.Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: P.G.	13c. CITY OR TOWN: Bowie	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 12013 Maddox Lane 20715	
14. FATHER'S NAME FIRST: John	MIDDLE: O.	LAST: Luster	15. MOTHER'S MAIDEN NAME FIRST: Lula	MIDDLE	LAST: Johnston
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-28-3990	17. INFORMANT ADDRESS: Emma F. Luster-Same as # 13 above		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1h
DUE TO, OR AS A CONSEQUENCE OF (b): Cancer of lung
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12 19 88, to 1/6 19 89, that (I) (we) last saw the deceased alive on 1/6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

22b. SIGNATURE: Martin D. Weltz — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Martin D. Weltz, M.D.

22e. ADDRESS: 7525 Greenway Ctr. Dr. # 205 Greenbelt, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 2/13/89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM. PK.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: LANDOVER, P.G. MD.
24. FUNERAL DIRECTOR NAME: H.S. WASHINGTON & SONS	ADDRESS: 4925 Bladensburg Ave, N.E.	25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

6 DHMH - 16 60M 7/84 (VRA 15, 4)

Henry Lester February 8,1909 4:05A

Male Black June 3,1909 79

x

W. Va. U.S.A. Prince George's

Bowie 12013 Haddox Lane Chauffer U.S.Gov't.

Md. P.G. Bowie x 12013 Haddox Lane

John O. Lester Lula Johnston

No 214-28-3990 Emma P. Lester-Same as # 13 above

x

Martin D. Welty, M.D. Greenbelt, Md.

7525 Greenway Ctr. Dr. # 205

x 2/9/89

023155 FEB 7 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 005369

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Charles — MIDDLE: Roosevelt — LAST: Manley

2a. DATE KNOWN OF DEATH ☑ ESTIMATED ☐ — MONTH: 2 — DAY: 12 — YEAR: 89 — 2b. HOUR: M

3. SEX: Male — 4. RACE: Negro — 5. DATE OF BIRTH — MONTH: 11 — DAY: 17 — YEAR: 36 — 6. AGE (IN YEARS) LAST BIRTHDAY: 52 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD — MONTH: 2 — DAY: 12 — YEAR: 89 — 2d. HOUR: 3p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina — 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: Temple Hills — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4007 19th Avenue — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher — 12b. KIND OF BUSINESS OR INDUSTRY: Pub Schools

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Prince Georges — 13c. CITY OR TOWN: Temple Hills — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 4007 19th Ave 20748

14. FATHER'S NAME — FIRST: John — MIDDLE — LAST: Manley

15. MOTHER'S MAIDEN NAME — FIRST: Geneva — MIDDLE: Not Stated (Unknown) — LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Unknown — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 003-30-0530

17. INFORMANT: Jacqueline Manley, Wife — ADDRESS: Temple Hills, Md 4007 19th Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-12-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal/Burial — 23b. DATE: 14 Feb 89 — 23c. NAME OF CEMETERY OR CREMATORY: Harrillsville Chapel Cem — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Harrillsville, North Carolina

24. FUNERAL DIRECTOR: Johnson & Jenkins Inc. — ADDRESS: Washington, D. C.

25a. DATE REC'D BY REGISTRAR: FEB 15 1989 — 25b.

TO MEDICAL EXAMINER: CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024942 MAR 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05870
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charles	MIDDLE:	LAST: Marshall, Jr.	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH DAY YEAR: 2-20-89 19	2b. HOUR M			
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: December 2, 1943	6. AGE (IN YEARS LAST BIRTHDAY): 45 YRS.	IF UNDER 1 YR. MONTHS / DAYS:	IF UNDER 24 HRS. HOURS / MIN.:	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-20-89 19	2d. HOUR: 2:16 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mississippi	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.				
10. CITY OR TOWN OF DEATH: Seat Pleasant	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6500 Central Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Auto Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Private				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: Seat Pleasant	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS: 6527 Adak Street 20743			
14. FATHER'S NAME FIRST: Charlie	MIDDLE:	LAST: Marshall, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Vivian	MIDDLE:	LAST: Anderson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 577-58-8092	17. INFORMANT: Catherine Rogers District	ADDRESS: 6903 Halleck St., Hgts, MD.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fatty liver
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Alcoholism
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-21-89

VC EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle, Jr., M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 26, 1989	23c. NAME OF CEMETERY OR CREMATORY: Willow Park Cemetery	23d. LOCATION CITY OR TOWN: Jackson	COUNTY / STATE: Mississippi
24. FUNERAL DIRECTOR NAME: John T. Stewart III		25a. DATE REC'D. BY REGISTRAR: MAR 01 '89	25b. REGISTRAR'S SIGNATURE: Erika Davidson-Randall	
Stewart Funeral Home-4001 Benning Road, N.E.				

07/84 25M BP_____

DHMH - 17 (VR A15 ME (5))

(3)

25202 MAR 14 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05871
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	LUCIENNE G. MASON	2a. DATE OF DEATH MONTH DAY YEAR	February 28, 1989	2b. HOUR 7:00 A.M.
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	December 20, 1894	6. AGE (IN YEARS LAST BIRTHDAY)	94 YRS.	IF UNDER 1 YEAR MONTHS DAYS / IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	France	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Prince Georges MD.	
10. CITY OR TOWN OF DEATH	Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Sacred Heart Home, Inc.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife	12b. KIND OF BUSINESS OR INDUSTRY	OWN HOME	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
VA.	ARLINGTON	N/A	YES ☐ NO ☒	1704 N. TROY ST. 99999

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
MATHIEU Guillerault	MARIE PAULE GARNAULT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		045-38-0537	JOHN BERGEN	988 BLVD. OF THE ARTS, SARASOTA FLA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) NATURAL CAUSES — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: N/A
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SENILE DEMENTIA; ARTHRITIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/22, 19 88, to 2/28, 19 89, that (I) (we) last saw the deceased alive on ____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2/28/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) H SCHISLER MD — 22e. ADDRESS 7500 Greenway Ctr Dr. Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	3/3/89	ARLINGTON NATIONAL	ARLINGTON, VA.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MURPHY FUNERAL HOME/4510 WILSON BLVD. ARLINGTON, VA.	MAR 7 1989	Julia Davidson-Randall

BP____

99999

DHMH - 16 60M 7/84 (VRA, 15, 4)

024907 MAR - 3 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005372

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Goldie	C.	Matthews	Fegruary 13, 1989	9:38P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Cauc.	Jan. 22 1901	88 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Kentucky	USA		Prince Georges MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	AMI Doctors Of Lanham	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. Geo.	Lanham	YES ☒ NO ☐	9204 6th. St. 20706

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Benjamin	Jackson		Elizabeth	Woods	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		238-06-6890	Ruth Dawson Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intracerebral Hemmorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis + Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Coronary Artery Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒ XX	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1988 19____ to 2-13 89 19____, that (I) (we) last saw the deceased alive on 2-13-89 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2-14-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A. C. LARA, MD	9324 Lanham-Severn Rd. Lanham

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/16/89	Ft. lincoln Cem.	Brentwood, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Rendon/Hale Funeral Home 9013 Annapolis RD. Lanham, Md. 20706	FEB 15 '89	Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

024980 MAR-8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 05873

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Aubrey		MAYHEW	February 12, 1989	12:40AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	Sept 8 1908	80 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	USA		Prince George County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	Doctors Hospital	Maintenance Tech	Wash. Redskins

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Geo.	Suitland	YES ☐ NO ☒	4302 Hartford Hills Drive

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Aubrey	Bernard	Mayhew	UNKNOWN		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
YES	WWII	579 09 9745	Marguerite Mayhew/wife/same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia Bilateral and Effusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Emphysema with — 3 yrs

DUE TO, OR AS A CONSEQUENCE OF (c) Atrial Fibrillation Fair Fair Mitral

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/6/89 to 2/6/89, that (I) (we) last saw the deceased alive on 2/6/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Kenneth S. Pearson MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-17-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
KENNETH S. PEARSON MD	6166 OLD SILVER HILL ROAD, FORESTVILLE MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb 15 1989	Lakemont Memorial	Davidsonville A.A. MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert E Wilhelm Funeral Home	Suitland MD	FEB 17 '89	Julia Davidson-Randolph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024785 MAR 7 83

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05874
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Rosa		Mays	February 15, 1989	7:40A.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	BLACK	October 11, 1910	78 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
North Carolina	U.S.A.		Prince Georges MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Forestville	Regency Nursing Home	Retired	Montgomery County Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
District of Columbia		Washington	YES ☒ NO ☐	1316 Eye Street, N.E. 99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Soernce		Sharp	Mary	Magdalene	Battle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	577-34-1162	Hanna McGee	1815 A Street, S.E. Washington, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 Days

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Senile Dementia Old Cerebrovascular Accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from March 28, 19 87, to February 15 89, that (I) (we) last saw the deceased alive on January 28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
J. Sanford Young	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	Feb. 15, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. Sanford Young, M.D.	11701 Livingston Road Fort Washington, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 20, 1989	Harmony Memorial	Landover, Maryland

24a. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John T. Stewart, III Stewart Funeral Home	4001 Benning Road, N.E. Washington, D.C.	FEB 21 89	Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84 (VRA 15, 4)

BP

022469 FEB 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05875
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Anna — MIDDLE: — LAST: McClister

2a. DATE OF DEATH — MONTH DAY YEAR: February 7, 1989 — 2b. HOUR: 10:05a M

3. SEX: Female

4. RACE: Caucasian

5. DATE OF BIRTH — MONTH DAY YEAR: July 12, 1900

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County, MD.

10. CITY OR TOWN OF DEATH: Lanham

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctor's Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Bowie — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 2515 Korvale Lane/20715

14. FATHER'S NAME — FIRST: James — MIDDLE: — LAST: Smith

15. MOTHER'S MAIDEN NAME — FIRST: Ellen — MIDDLE: Ada — LAST: Merchant

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 145-07-8108

17. INFORMANT — ADDRESS: Nancy A. Conaway, Same as # 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Hemorrhagic Cerebral Infarct

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension.

DUE TO, OR AS A CONSEQUENCE OF (c): Septicemia.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Sick Sinus Synchome, Permanent Pacemaker

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-14 19 89, to 2-7- 19 89, that (I) (we) last saw the deceased alive on 2-7- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph Arora, MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Rakesh Arora, M.D.

22e. ADDRESS: 14300 Gallant Fox Lane Bowie, MD 20715

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: Feb. 7, 1989

23c. NAME OF CEMETERY OR CREMATORY: Metropolitan Crematory

23d. LOCATION — CITY OR TOWN: Alexandria, COUNTY: Fairfax, STATE: Virginia

24. FUNERAL DIRECTOR — NAME: Beall-Evans Funeral HOme, P.A. — ADDRESS: 16000 Annapolis Rd. Bowie, MD 20715

25a. DATE REC'D. BY REGISTRAR: FEB 09 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasa

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023803 FEB 2 [illegible]

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005876

1. DECEASED NAME (TYPE OR PRINT): FIRST Luther MIDDLE James LAST McCloud

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 13 YEAR 1989 — 2b. HOUR M

3. SEX: Male — 4. RACE — 5. DATE OF BIRTH: MONTH 2 DAY 23 YEAR 15 — 6. AGE (IN YEARS IF NOT BIRTHDAY): 73 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 13 YEAR 1989 — 2d. HOUR 10:45 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: PG County MD.

10. CITY OR TOWN OF DEATH: Md — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired — 12b. KIND OF BUSINESS OR INDUSTRY: Gen Motors

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: PG — 13c. CITY OR TOWN: Ft. Wash — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 12410 Proxmire Drive 20744

14. FATHER'S NAME: FIRST Willie MIDDLE LAST McCloud

15. MOTHER'S MAIDEN NAME: FIRST Estella MIDDLE LAST Crockett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 243-03-5167

17. INFORMANT: Mr. David McCloud/son/same as 13e — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Post subacute endocarditis; cardiac pacemaker

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez — TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED 2-13-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2-18-89 — 23c. NAME OF CEMETERY OR CREMATORY: Mountain View — 23d. LOCATION CITY OR TOWN: Surry County, COUNTY N.C. STATE

24. FUNERAL DIRECTOR NAME ADDRESS: John T. Rhines Co., 3015 12th St., N.E. D.C. 20017 — 25a. DATE REC'D. BY REGISTRAR: FEB 21 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Taylor Rhines

DIVISION OF VITAL RECORDS; 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

same as 136

em

025301 MAR 14, 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05877
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Mary	V.	McDugald	Feb.	12,	1989	4:35PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	April	19,	1897	91 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Kentucky	U.S.A.		Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hyattsville	Carroll Manor	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
---	---	Washington, DC	YES ☒ NO ☐	5366-28th Street, N.W./20015

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Bedford	E.	Vaughn	Prudence	--	Pollard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	---	265-26-4143	J. McDugald, Same address as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	12 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b)	BIVENTRICULAR FAILURE	5 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	END STAGE PULMUNARY FIBROSIS	YEARS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from AUGUST 25, 19 88, to FEBRUARY 12 19 89, that (I) (~~we~~) last saw the deceased alive on FEBRUARY 11 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Marta Anne Schneider MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb. 13, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Marta A, Schneider	5401 MacArthur Blvd, NW, Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Cremation	2/13/89	Mt. Comfort Crematory	Alexandria,	VA	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc.	5130 Wisconsin Ave, NW, Washington, D.C. 20016	FEB 15'89	Gina Davidson-Randell

BP 3

DHMH 16.50M 1/81 (VRA 15, 4)

0249 12 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

89 05878 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): John (FIRST) Thomas (MIDDLE) McGlynn (LAST)

2a. DATE OF DEATH: Feb 12 1989 (MONTH DAY YEAR) | 2b. HOUR: 7P M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: Feb. 1 1909 (MONTH DAY YEAR)

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mass.

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Laurel

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Veterans Administration

12b. KIND OF BUSINESS OR INDUSTRY: Federal Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland | 13b. COUNTY: Mont. | 13c. CITY OR TOWN: Wheaton | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 3603 Ralph Road 20906

14. FATHER'S NAME: Thomas (FIRST) James (MIDDLE) McGlynn (LAST)

15. MOTHER'S MAIDEN NAME: Mary (FIRST) (MIDDLE) Downs (LAST)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 021-01-1888

17. INFORMANT: Elizabeth McGlynn | ADDRESS: same as 13 e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b): Bilateral Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Right frontal lobe Infarct

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-3 19 89 to 2-12 19 89, that (I) (we) last saw the deceased alive on 2-11 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R Bhojraj MD | DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 2-12-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): R.G. BHOJRAJ, M.D. | 22e. ADDRESS: 704 Gorman Ave T-1, Laurel, MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 2/16/89 | 23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery | 23d. LOCATION CITY OR TOWN: Rockville COUNTY: Montgomery STATE: Maryland

24. FUNERAL DIRECTOR NAME: Fleck Funeral home, Inc. ADDRESS: 7601 Sandy Spring Road Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR: FEB 16 '89 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

8 1-VA BP

DHMH - 16 60M 7/84 (VRA 15, 4)

0229695 FEB 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 90 05979

1. DECEASED NAME (TYPE OR PRINT): FIRST Marianne MIDDLE Mabel LAST McVey

2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐: MONTH 2 DAY 4 YEAR 1989

2b. HOUR 1A M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 5 DAY 2 YEAR 13

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.

IF UNDER 1 YR. MONTHS / DAYS

IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 4 YEAR 1989

2d. HOUR 10:45 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): England

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.

10. CITY OR TOWN OF DEATH: Riverdale

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS): 5309 Riverdale Rd Apt 215

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Waitress

12b. KIND OF BUSINESS OR INDUSTRY: Restaurants

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Prince George

13c. CITY OR TOWN: Riverdale

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 5309 Riverdale Rd #215

14. FATHER'S NAME: FIRST (Unavailable) MIDDLE LAST

15. MOTHER'S MAIDEN NAME: FIRST (Unavailable) MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-38-8816

17. INFORMANT (ADDRESS): (Friend) 5309 Riverdale Rd. #215
Joseph Juliano Riverdale, Md. 20737

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease — 4 years
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION: N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Paul A. DeVore M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER, DATE SIGNED: 2-4-89

EXAMINER'S NAME (TYPE OR PRINT): Paul A. DeVore, M.D. ADDRESS: 4203 Queensbury Rd Hyattsville MD 20781

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02/07/89

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION CITY OR TOWN: Brentwood COUNTY: P.G. STATE: Maryland

24. FUNERAL DIRECTOR (NAME, ADDRESS): Francis Gasch's Sons Funeral Home P.A.
4739 Baltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR: FEB 9 '89

25b. REGISTRAR'S SIGNATURE: Gwendolyn Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024750 MAR 17 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005880 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH	DAY	YEAR 19	2b. HOUR M
Theresa	Drummond	Meck	2-15-		89	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19	2d. HOUR M
FEMALE	WHITE	AUG. 27, 1960	28 YRS.			2-15- 89	4:20P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED X	9. BALTIMORE CITY OR COUNTY OF DEATH				
FRANCE	U.S.A.		Prince Georges County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Camp Springs	Andrews Air Force Base	ENLISTED	U.S.NAVY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS			
MD	ST. MARYS	MECHANICSVILLE		RD 1 BOX 382	20659		
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST		
LOUIS	ALLEN	DRUMMOND	BETTY	MAE	MUSGROVE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
YES	ACTIVE DUTY	141-60-6247	LOUIS A. DRUMMOND	407 PRESTON RD CHERRY HILL, NJ			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple injuries	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2-15-89 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/truck collision
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road	21f. LOCATION CITY OR TOWN Suitland Parkway/Allentown Road, Camp Springs COUNTY Prince Georges Co.MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER DATE SIGNED 2-16-89

VC EXAMINER'S NAME (TYPE OR PRINT) James Kaplan, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-22-1989	CALVARY CEMETERY	CHERRY HILL, CAMDEN, N.J.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
W. W. CHAMBERS CO. INC. SILVER SPRING, Md. 20910	FEB 23 '89	Gloria Davidson-Randall	

07/84 25M BP_____ DHMH - 17 (VR A15 ME (5))

023690 FEB 28 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached to give us the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005881
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSEPH	MIDDLE: DANIEL	LAST: MELILLO, Sr.	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 8 1989	2b. HOUR: 11:10 am	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 07 1930	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.		
10. CITY OR TOWN OF DEATH: Andrews A.F.B.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Malcolm Grow Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Master Sgt.Ret.U.S.A.F.	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Charles	Cobb Island	YES ☐ NO ☒	858 Northwest Crain Blvd.20625

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Albert / / Melillo	Agnes / / Meeken

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1949-1969	068-24-7662	Marian A. Melillo, Cobb Island, Md.	858 NW Crain Blc

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTASIZED LUNG CANCER
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 26 JAN 19 89 to 8 FEB 19 89, that (I) ~~(we)~~ last saw the deceased alive on 8 FEB 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: X [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 02-09-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KATHLEEN M. ANKERS, CAPT, USAF, MC

22e. ADDRESS: MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB MD 20331-5300

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-13-89	Md.Vets.Cemetery	Cheltenham, P.G. ,Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arehart Funeral Home, Inc., La Plata, Md.	FEB 10 '89	Julia Davidson Randall

24314 FEB 29 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05882
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Loretta	MIDDLE: K.	LAST: Messenger	2a. DATE OF DEATH MONTH: February	DAY: 20,	YEAR: 1989	2b. HOUR: M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: Oct. DAY: 23 YEAR: 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.				
10. CITY OR TOWN OF DEATH: Bowie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 12003 Marvel Lane 20715	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
New York	Orange	Cornwall on Hudson	YES ☐ NO ☐	21 Andrew Street/12520

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	J.	Kinsler	Sarah	V.	McMahon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		072-03-9568	George H. Messenger	12003 Marvel Lane Bowie, MD 20715

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BREAST CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PATHOLOGIC FRACTURE RIGHT HUMERUS; BRAIN METASTASIS; CELLULITIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 2-9 19 89 to 2-20 19 89 that (I) (we) last saw the deceased alive on 2-19 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Michael York MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-20-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL YORK MD	5506 Green Landing Rd. Upper Marlboro MD 20772

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/23/89	St. Thomas Cemetery	Cornwall, Orange, New York

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral HOme, P.A. 16000 Annapolis Rd. Bowie, MD 20715	MAR 1 - 1989	Gloria Anderson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 1/81 (VRA 15, 4)

U24944 MAR-8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 FOR STATE REGISTRAR — 89 REG. NO. 05883

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSEPH	MIDDLE	LAST: MCKIE	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 23 1989	2b. HOUR: 3:16 P M	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: January 22, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Andrews A.F.B. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Government		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: Capitol Heights	13d. INSIDE CITY LIMITS? NO [X]	13e. STREET ADDRESS: 7702 Beechnut Road 20743
14. FATHER'S NAME FIRST: Joseph	MIDDLE	LAST: McKie, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Mattie	MIDDLE: L. LAST: Jennings
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): Army	16b. SOCIAL SECURITY NO.: 383-18-1782	17. INFORMANT: MayBell McKie	ADDRESS: 7702 Beachnut Road Capitol Heights, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRAIN HERNIATION (TRANSTENTORIAL)
DUE TO, OR AS A CONSEQUENCE OF
(b) MASSIVE RIGHT HEMISPHERIC CVA
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ~~I~~ (this hospital) attended the deceased from 21 February, 1989, to 23 February, 1989, that ~~I~~ (we) last saw the deceased alive on 23 February 1989, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Chas A. Weber	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 25 FEB 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES A WEBER, CAPT, USAF, MC	22e. ADDRESS: MALCOLM GROW USAF MED CEN ANDREWS AFB MD, 20331-5300		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 28, 1989	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION CITY OR TOWN: Arlington COUNTY: Virginia STATE:	
24a. FUNERAL DIRECTOR NAME: Stewart, III	ADDRESS: 4001 Benning Road Stewart Funeral Home Washington, D.C.	25a. DATE REC'D. BY REGISTRAR: MAR 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The remaining carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, either homicidal or accidental event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

5 BP

DHMH - 1650M 1/81 (VRA 15, 4)

023125 FEB 17 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05884 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST ANN MIDDLE GILMAN LAST MILLER

2a. DATE OF DEATH: MONTH 02 DAY 11 YEAR 89

2b. HOUR: 1 15PM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH October DAY 5, YEAR 1914

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Arkansas

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH: CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince Georges

13c. CITY OR TOWN: Hyattsville

13d. INSIDE CITY LIMITS? YES XX NO ☐

13e. STREET ADDRESS: 5708 37th Avenue 20782

14. FATHER'S NAME: FIRST Will MIDDLE LAST Gilman

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE LAST Kris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 247-34-5848

17. INFORMANT: Wendy F. Miller ADDRESS 4108 Culver Street, Kensington, Maryland 20895

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): cardio - pulmonary arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): cerebrovascular accident Sepsis, Atelectasis,

DUE TO, OR AS A CONSEQUENCE OF (c): acute renal failure, visceral hemorrhage etc.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus, Cataracts, S/P surgery for pulmonary tuberculosis.

19a. DATE OF OPERATION: 10/24/11/84 & 1/88

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPSY? YES ☐ NO XX

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/24 19 88 to 2/11 19 89 that (I) (we) last saw the deceased alive on 2/11/89 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jerry E Cohen DEGREE ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Leroy E Cohen

22e. ADDRESS: 6201 Greenbelt Road, College Park, Maryland 20740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/13/1989

23c. NAME OF CEMETERY OR CREMATORY: King David Mem. Garden

23d. LOCATION: CITY OR TOWN Falls Church COUNTY STATE Virginia

24. FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR: FEB 15 1989

25b. REGISTRAR'S SIGNATURE: Meridon Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

022103 FEB 89

D-68 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005885 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: BERTHA	MIDDLE	LAST: MILLISON	2a. DATE OF DEATH MONTH: 02 DAY: 05 YEAR: 1989	2b. HOUR: 9:35 PM	
3. SEX: Female	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 10 DAY: 18 YEAR: 06	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES CO. MD.		
10. CITY OR TOWN OF DEATH: Greenbelt, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): GREENBELT NURSG CENTER	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): MERCHANT	12b. KIND OF BUSINESS OR INDUSTRY: GROCERY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	PRENCE GEORGE'S	LANHAM	YES ☒ NO ☐	5625 DUCHAINE DRIVE 20706

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
GOODMAN		BERGER	SARA	BELLA	BUMSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		577362410A	IRA S. ROSENZWEIG,	5625 DUCHAINE DRIVE LANHAM, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Stroke

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Peripheral Vascular Insufficiency

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Gangrene of both legs.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/24/1973 to 2/5/89, that (I) (we) last saw the deceased alive on 2/5/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 3/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): T. ABOLITZ M.D.

22e. ADDRESS: 8924 Cunningham Drive

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / STATE
BURIAL	2/8/1989	MOUNT LEBANON CEMETERY	ADELPHI, PR. GEO., MARYLAND

24a. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME	232 CARROLL STREET, N. W., WASHINGTON, D. C.	FEB 8 1989	Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

025090 MAR -9 89 Item#1821a,b,c,d,e,f,22a per med

FOR 1- STATE REGISTRAR 3/23/89 FilmG649cg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005886 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Lawrence		Mills	2-19		1989	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
MALE	BLACK	1-17-61	28 YRS.			2-19 1989	1:00 p.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Wash.D.C.	U.S.A.		Prince George's County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Landover	8433 Hamlin Street, #204	MAINTENANCE	PRIVATE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
MD	P.G.	LAndover		8433 Hamlin ST. 2125

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
George A. Mills	Elder Warren		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	N/A	Elder ~~Mills~~	525 25th PL N.E. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Diabetic ketoacidosis complicating cocaine, PCP and narcotic

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF use

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
	2/19 1989	Unknown	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	
	Home	8433 Hamlin St. Landover, Prince George Co. Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-20-89

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	25Feb 89	Harmony Cemetery	Landover P.G? Maryland

24. FUNERAL DIRECTOR NAME MODERN FUNERAL HOME ADDRESS 3821 14th ST.N.W. D.C.		25a. DATE REC'D. BY REGISTRAR FEB 24 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

07/84 25M BP 399 DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05887 REG. NO.

023936 FEB 28 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1a. DECEASED NAME (TYPE OR PRINT) FIRST: LEWIS	MIDDLE: C.	LAST: MINOR	2a. DATE OF DEATH MONTH DAY YEAR: 02 14 89	2b. HOUR: 7.20A M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: JULY 21 1926	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): WAREHOUSE WORKER	12b. KIND OF BUSINESS OR INDUSTRY: FORMAN BROTHERS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: P.G.	13c. CITY OR TOWN: LANDOVER	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 3424 DODGE PARK ROAD 20784
14. FATHER'S NAME FIRST: LEWIS	MIDDLE: C.	LAST: MINOR	15. MOTHER'S MAIDEN NAME FIRST: EARL	MIDDLE	LAST: MINOR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-38-5442	17. INFORMANT: WILLIAM MINOR	ADDRESS: 6116 SEAT PLEASANT DR. SEAT PLEASANT MARYLAND	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of the stomach — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Hepatic failure
DUE TO, OR AS A CONSEQUENCE OF (c): Renal failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-17- 19 89, to 2-14- 19 89, that (I) (we) last saw the deceased alive on 2-13- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M. Briggs — DEGREE — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-14-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. BRIGGS — 22e. ADDRESS: 3416 Fort Meade Rd Lanrel Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-17-89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY CEMETERY	23d. LOCATION CITY OR TOWN: LANDOVER	COUNTY: P.G. STATE: M.D.
24. FUNERAL DIRECTOR NAME / ADDRESS: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019	25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP

DHMH-1650M 1/81
(VRA 15, 4)

024725 MAR-89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 058883
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: MARLENE	MIDDLE: F.	LAST: MITTELSTAEDT	2a. DATE OF DEATH MONTH DAY YEAR: 02-16-89	2b. HOUR: 12 10PM M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 26, 1947	6. AGE (IN YEARS LAST BIRTHDAY): 41 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wisconsin	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Christian School Private			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr.Geo's	Upper Marlboro	YES ☐ NO ☒	1490 Brown Station Rd/20772

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Delmer	--	Hallemeyer	Gertrude	--	Schramm

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---		Rev. John R. Mittelstaedt-Rd.,	1490 Brown Station Upper Marlboro MD. 20772

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	pulmonary congestion & cardiac arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Progressive central nervous system deterioration	
DUE TO, OR AS A CONSEQUENCE OF (c)	Brain stem malignant	3-4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-15, 1989, to 2-16, 1989, that (I) (we) last saw the deceased alive on 2/15, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James W Harding MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John W. Harding, M.D.	7525 Greenway Cntr., Greenbe.t, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/21/89	Geo.Washington Cem.	Adelphi (Pr.Geo's) Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE ACCEPTED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Richard A. Coleman Funeral Home	Upper Marlboro, Md. 20772	MAR 2 1989	[signature] Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

023862 FEB 26 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05389
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Annie	MIDDLE: M.	LAST: Mobley	2a. DATE OF DEATH MONTH DAY YEAR: 2-16-89	2b. HOUR: 10:08 P M	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 12-26-15	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Beltsville Laurel Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	PG	Laurel	YES [X] NO [ ]	15111 Kalmia Drive 20707

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Dause Outlaw	Classie Andrews	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	577-54-2871	Annie E. White: 15111 Kalmia Dr.; Laurel, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (b): Pancreatic Carcinoma

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Md.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-4- 19 89, to 2-16 19 89, that (I) (we) last saw the deceased alive on 2-16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Gary W. Jones, MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Gary W. Jones, M.D.	P.O. Box 385 Laurel, Md. 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-21-89	Maryland National Mem Park	Laruel Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Marshall's Funeral Home 4217 9th St NW: Washington, D.C.	FEB 23 1989	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024906 MAR 8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

89 005390
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dale	MIDDLE: Eugene	LAST: Mondell	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH: 2	DAY: 7	YEAR: 89	2b. HOUR: M
3. SEX: Male	4. RACE: Cau.	5. DATE OF BIRTH MONTH: May DAY: 8 YEAR: 1963	6. AGE (IN YEARS LAST BIRTHDAY): 25 YRS.	IF UNDER 1 YR. MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN:	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 7 YEAR: 89	2d. HOUR: 10:00 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.				
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Technician	12b. KIND OF BUSINESS OR INDUSTRY: Telecom				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Georges	Upper Marlboro	YES ☐ NO ☒	8877 Fairhaven Ave. 20772

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	Eugene	Mondell	Peggy	Joyce	Pope

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	----------	217-92-7310	Kim Lemon same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gunshot wound of head	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	9:00 PM 2-6-89	Subject shot

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	in auto	9200 block Darcy Road, Upper Marlboro, Prince Georges County, MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide XX Undetermined manner ☐

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) M.D. ASSISTANT MEDICAL EXAMINER MEDICAL EXAMINER DATE SIGNED 2-8-89

VC EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Feb. 10, 1989	Resurrection Cemetery	Clinton, Prince Georges, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home P.O. BOX 156 Waldorf, Maryland 20604	FEB 14 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10

07/84 25M

BP

DHMH - 17
(VR A15 ME (5))

024797 MAR -7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005891

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: LYLE	Middle: Wilfred	Last: Monson	2a. DATE OF DEATH Month: Feb	Day: 17	Year: 1989
2b. HOUR: 2:42 P M					
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH Month: Jan. Day: 20 Year: 1918	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Canada	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor-Food Service	12b. KIND OF BUSINESS OR INDUSTRY: Walter Reed		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. George's	College Park	YES ☒ NO ☐	9244 Limestone Place 20740

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edwin	L.	Monson	Ruth		Peterson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	502-05-8510	Alphina S. Monson	same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma lung

DUE TO, OR AS A CONSEQUENCE OF (c): Metastatic ca: lung to liver & Bone -

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-17- 19 89, to 2-17- 19 89, that (I) (we) last saw the deceased alive on 2-17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MUSHTAQ A. SHAH.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-21-89	George Washington Cem.	Adelphi, Pr. George's, Md.

24. FUNERAL DIRECTOR (NAME) / ADDRESS	25c. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781	FEB 21 89	Julia Davidson-Randall

(20) IVA

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023135 FEB 17 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005892

1. DECEASED NAME (TYPE OR PRINT) FIRST: WILLIAM	MIDDLE: THOMAS	LAST: MORGAN	JR	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 8 1989	2b. HOUR: 1220p M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 16, 1925		6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): georgia	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.	
10. CITY OR TOWN OF DEATH: Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Malcolm Grow USAF Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pilot	12b. KIND OF BUSINESS OR INDUSTRY: US Air Force
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George's	13c. CITY OR TOWN: Upper Marlboro	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 9505 Sherwood Drive	20772
14. FATHER'S NAME FIRST: William	MIDDLE: Thomas	LAST: Morgan, SR		15. MOTHER'S MAIDEN NAME FIRST: Mattie	MIDDLE	LAST: Hobbs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II, Korea	16b. SOCIAL SECURITY NO.: 577-22-3537	17. INFORMANT: Barbara Morgan		ADDRESS: 9505 Sherwood Drive Upper Marlboro, MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b): CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO XX
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 8 Feb 19 89, to 8 Feb 19 89, that I (we) last saw the deceased alive on 8 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R S Schaller DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 8 FEB 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT N. SCHALLER, MAJ, USAF, MC

22e. ADDRESS: MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB MD 20331-5300

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 13, 1989	23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington, VA.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Ives-Pearson Funeral Homes 2847 Wilson Blvd., Arlingotn, Va. 22201

25a. DATE REC'D. BY REGISTRAR: FEB 15 1989 25b. REGISTRAR'S SIGNATURE: Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of each.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024730 MAR-6 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 058933
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Carl	Bristow	MORRIS	February 22, 1989	8:12P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	BLACK	4-5-03	85 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Kentucky	United States		Prince Georges MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LANHAM	DOCTORS HOSPITAL OF LANHAM	Chauffeur	Nogul Brass

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Seabrook	YES ☒ NO ☐	6407 98th Ave. 20801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Unk.		Morris	Mary		Payton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		405-18-9570	Flora Morris-6407 98th Ave.-Seabrook, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a):
Renal Failure - Hepatic Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct 19 88 to 2/22 19 89, that (I) (we) last saw the deceased alive on 2/22 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we)) (did) (did not) view the body after death.

22b. SIGNATURE Alex H Chung, MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-27-89	Fort Lincoln Cemetery	Brentwood, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Alexander S. Pope	2617 Pennsylvania Ave. S.E	MAR 2 - 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024948 MAR 1-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005894
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: LEVERN	MIDDLE: CALVIN	LAST: MORROW	2a. DATE OF DEATH: MONTH FEBRUARY	DAY 25	YEAR 1989	2b. HOUR 3:40 PM
3. SEX: MALE	4. RACE: CAU.	5. DATE OF BIRTH: MONTH JULY	DAY 23	YEAR 1930	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ALABAMA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: ANDREWS AFB	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MALCOLM GROW HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): S/SGT.	12b. KIND OF BUSINESS OR INDUSTRY: USAF	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	PG	SUITLAND	YES [ ] NO [X]	3526 SILVER PK DR 20746

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
FIRST: Herb / MIDDLE / LAST: MORROW	FIRST: EVIE / MIDDLE / LAST: RIDDLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): KOREAN/VIETNAM	16b. SOCIAL SECURITY NO.: 418 40 6658	17. INFORMANT: WIFE / ADDRESS: CATHERINE ADELE MORROW #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC/RESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): END STAGE CIRRHOTIC LIVER DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 JAN 89 to 25 FEB 89, that (I) (we) last saw the deceased alive on 25 FEB 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (and did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 25 FEB 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LEWIS A HOFMAN, CAPT, USAF, MC

22e. ADDRESS: MGMC, ANDREWS AFB, MD 20331-5300

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
BURIAL	3-1-89	ARLINGTON NATIONAL	ARLINGTON ARLINGTON VA.

24. FUNERAL DIRECTOR: NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HUNTT FUNERAL HOME P.O. Box 156 WALDORF, MD. 20604	MAR 1 '89	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023915 FEB 28 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005895 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove blank pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Thi	Middle: Dang	Last: Nguyen	2a. DATE OF DEATH Month/Day/Year: January 31, 1989	2b. HOUR: 9:30 PM	
3. SEX: Male	4. RACE: Vietnamese	5. DATE OF BIRTH Month/Day/Year: Oct. 8, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Vietnam	7b. CITIZEN OF WHAT COUNTRY?: Vietnam	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Elem.Sch.Teacher Ret.	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. Geo.	13c. CITY OR TOWN: Lanham	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 7315 Oliver St. 20706	
14. FATHER'S NAME First Middle Last: Muu Dang Nguyen		15. MOTHER'S MAIDEN NAME First Middle Last: Hin Thi Nguyen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 586-32-9708	17. INFORMANT ADDRESS: Hang Nguyen Same as 13e		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio pulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO, OR AS A CONSEQUENCE OF (b): Septic Shock

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): acute renal failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Essential hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/29 19 89 to 1/31 19 89, that (I) (we) last saw the deceased alive on 6:15 pm 1/31 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/1/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): TON THAT CHIEU, MD	22e. ADDRESS: 7505 New Hampshire Av. Suite 310 Langley Park, MD 20783		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/4/89	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706	25a. DATE REC'D BY REGISTRAR: FEB 3 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

024190 FEB 23 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005896

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Annie	Middle: Leone	Last: Nixon.	2a. DATE OF DEATH Month: 2	Day: 21	Year: 89	2b. HOUR: 7:10 A M
3. SEX: Female	4. RACE: Caucasian W	5. DATE OF BIRTH Month: 03	Day: 03	Year: 03	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.				
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia	13b. COUNTY: Chesterfield	13c. CITY OR TOWN: Chester	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS: 2992 Mount Clair Rd	23831		
14. FATHER'S NAME First: David	Middle: Christy	Last: Nelson	15. MOTHER'S MAIDEN NAME First: Alda	Middle:	Last: Allred		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 242-03-9579-D	17. INFORMANT: Grady L. Nixon	ADDRESS: 9618 Glen Way Ft. Washington, MD20744			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Aspiration of tube feedings.
DUE TO, OR AS A CONSEQUENCE OF (c): Mal/nutrition
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Sepsis, Congestive Heart failure & ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-89 19 89, to 2-21 19 89, that (I) (we) last saw the deceased alive on 2-20 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Oswald L Haye MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Oswald L Haye — 22e. ADDRESS: 9131 Rectaway Rd Clinton Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/24/89	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION CITY OR TOWN: Chester	COUNTY: Chesterfield STATE: Va.
24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. ADDRESS: 6633 Old Alexander Ferry Rd Clinton, Md 20735		25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

022464 FEB 13 89 FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053997 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CARLTON	MIDDLE: L.	LAST: NORRIS	2a. DATE OF DEATH MONTH DAY YEAR: 02 - 07 - 1989	2b. HOUR: 12-30 A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 09 - 29 - 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: UNIted States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE COUNTY MD.		
10. CITY OR TOWN OF DEATH: Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): LELAND MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales person	12b. KIND OF BUSINESS OR INDUSTRY: PRIVATE		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	College Park	YES [X] NO [ ]	9014 Rhode Island Ave. 20740

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	
FIRST: Warren MIDDLE: LAST: NOrris	FIRST: Maybell MIDDLE: LAST: Hobbs	College Park, Md.

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT
Yes	WWII	556-36-1080	Lelia Norris (wife) 4820 Osage St. 20740

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (c): Acute Bronchospasm

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chronic obstructive Pulmonary Disease; Status post Laryngectomy for Carcinoma Larynx

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
[ ]		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 2-6- 19 89, to 2-7- 19 89, that (I) (we) last saw the deceased alive on 2-6- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	M.D ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	2-7-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
G. M. DIN, M.D	650 Kenilworth Ave Riverdale MD. 20737

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-9-1989	Cedar Hill Cemetery	Suitland P.G. MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Donald Borgwardt	4400 Powder Mill Rd. Beltsville, Md. 20705	FEB 09 1989	Julia Davidson-Rendaza

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024904 MAR - 8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 053983
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
NELL	R.	O'BRIEN	02	07	89 / 12.58A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Female	White	Mar 4 1926	62 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA		PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER		Housewife Wife	Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr Geo	Cap Hgts	YES ☐ NO ☐	1211 Larchmont Avenue 20743

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James	A	Adams	Eliza	—	Mosky

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	226-22-9623	Jack O'Brien	1211 Larchmont Ave Cap Hgts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	REFRACTORY VENTRICULAR FIBRILLATION	30 Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	ISCHEMIC CARDIOMYOPATHY	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
(1) Recent Myocardial Infarction & Congestive Heart Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I (this hospital) attended the deceased from 29 Jan 19 89 to 7 Feb 19 89, that I (we) last saw the deceased alive on 6 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
M Schwartz	MD	☒ / ☐ / ☐	FEB. 7, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL SCHWARTZ	7500 Honeygo Blvd #103 Greenbelt, MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb 10 89	Washington National	Suitland	MarylAND	

24. FUNERAL DIRECTOR NAME	ADDRESS	25. DATE REC'D BY REGISTRAR	26. REGISTRAR'S SIGNATURE
Robert E Wilhelm FunerAL Home	SuitlaND MarylaND	FEB 10 89	Trudie Davidson-Randall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024786 MAR -7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005899
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DOROTHY	MIDDLE: E.	LAST: O DONNELL	2a. DATE OF DEATH MONTH DAY YEAR: 2-15-89	2b. HOUR: 4:50 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov 4 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Canada	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES Co MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): So. MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales Representative	12b. KIND OF BUSINESS OR INDUSTRY: Housewares		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	PG	Forestville	YES [X] NO [ ]	5052 Silver Hill Court 20747

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ernest	John	Wade	Eunice	Catherine	Petterson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	----------	017 14 2459	Thomas O'Donnell/husband/same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c): severe, arteriosclerotic Coronary Artery Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
[ ]		

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/13, 19 89, to 2/14, 19 89, that (I) (we) last saw the deceased alive on 2/14, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Glenn R. Jamison

22e. ADDRESS: 9450 Penn. Ave. #18 Upper Marlboro MD 20772

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb 17 1989	Lakemont Memorial	Davidsonville A.A. MD

24. FUNERAL DIRECTOR NAME / ADDRESS: Robert E Wilhelm Funeral Home Suitland MD

25a. DATE REC'D. BY REGISTRAR: FEB 17 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

024192 FEB 20 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 059 00

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Veronica — MIDDLE: — LAST: Oughton

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH: 2 — DAY: 19 — YEAR: 1989 — 2b. HOUR: M

3. SEX: Female — 4. RACE: Caucasian — 5. DATE OF BIRTH — MONTH DAY YEAR: Nov. 11, 1969 — 6. AGE (IN YEARS LAST BIRTHDAY): 19 YRS. — IF UNDER 1 YR. MONTHS: — DAYS: — IF UNDER 24 HRS. HOURS: — MIN.: — 2c. DATE PRONOUNCED DEAD — MONTH: 2 — DAY: 19 — YEAR: 1989 — 2d. HOUR: 3:56 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Texas — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.

10. CITY OR TOWN OF DEATH: Clinton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): student — 12b. KIND OF BUSINESS OR INDUSTRY: college

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Ft. Washington — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: 9105 Pinehurst Dr. 20744

14. FATHER'S NAME — FIRST: Robert — MIDDLE: J. — LAST: Oughton

15. MOTHER'S MAIDEN NAME — FIRST: Cindy — MIDDLE: Y. — LAST: Kong

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES): n/a — 16b. SOCIAL SECURITY NO.: 212-04-2608

17. INFORMANT: father: Robert Oughton — ADDRESS: 9105 Pinehurst Dr. Ft. Washington, MD 20744

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

8160

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 3 XX 2 19 1989 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver of auto lost control

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 14600 Blk. Brandywine Rd, Brandywine, P.G.CO, MD

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Margarita A. Korell — TITLE (SPECIFY): M.D. Assistant MEDICAL EXAMINER — DATE SIGNED: 2/19/89

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 Penn St. Balto. MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial — 23b. DATE: Feb. 22, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Heritage Memorial Park — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Waldorf, Charles MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: Lee Funeral Home, Inc. Old Alexander Ferry Rd., Clinton, MD 20735 — 6633

25a. DATE RECD. BY REGISTRAR: FEB 23 1989 — 25b. REGISTRAR'S SIGNATURE: [signature] Barbara Randall

FEB 23 1989 [signature] Barbara Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP

DHMH - 12 (VR A15 ME (87))

024979 MAR 8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

39 - 05901
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BERTHA	MIDDLE: H.	LAST: PAGE	2a. DATE OF DEATH MONTH DAY YEAR: 02-11-89		2b. HOUR: 8 18AM M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec 26 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	P.G.	Dist. Hghts	YES ☒ NO ☐	2104 Ramblewood Drive 20747

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Benjamin	T.	Henderson	Nettie	M.	Henderson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT Deale MD ADDRESS
NO	----------	992 39 8238	Nettie Wood/sister/5850 Deal Churchton Rd

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) NATURAL CAUSES — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-1 19 89, to 1/11 19 89, that (I) (we) last saw the deceased alive on 1/11 19 89, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (This) (did not) view the body after death.

22b. SIGNATURE Richard Mitchell for Donald Yablonowitz MD — DEGREE MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) P SCHISSLER MD — 22e. ADDRESS 7500 Greenway Ctr Dr Greenbelt 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb 15 1989	Cedar Hill Cemetery	Suitland / PG / MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert E Wilhelm Funeral Home	Suitland MD	FEB 17 '89	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

022274 FEB 10 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005902

1. DECEASED NAME (TYPE OR PRINT): FIRST Arthur; MIDDLE Leroy; LAST Page-E1

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] MONTH 2 DAY 3 YEAR 89 — 2b. HOUR

3. SEX: Male — 4. RACE: Black — 5. DATE OF BIRTH: MONTH 5 DAY 17 YEAR 59 — 6. AGE (IN YEARS LAST BIRTHDAY): 29 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 3 YEAR 19 89 — 2d. HOUR 12:38 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): S. C. — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Geroges General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpet Lager — 12b. KIND OF BUSINESS OR INDUSTRY: Self Employed

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md. — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Riverdale — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 5601 Longfellow Street 20737

14. FATHER'S NAME: FIRST Leroy; MIDDLE; LAST Page

15. MOTHER'S MAIDEN NAME: FIRST Hazel; MIDDLE; LAST Green

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: Unknown

17. INFORMANT ADDRESS: Mrs. Sharon A. Page/wife/same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound to the back of the chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. MONTH 2-2 DAY 89 YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject shot

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): passageway — 21f. LOCATION STREET OR R.F.D. 6906 Walkers Mill Road, CITY OR TOWN Capital Hghts, COUNTY Prince Georges County, STATE MD

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from Natural causes [ ], Accident [ ], Suicide [ ], Homicide [XX], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] — TITLE (SPECIFY) M.D. Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED 2-3-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2-10-89 — 23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem — 23d. LOCATION CITY OR TOWN: Landover, COUNTY, STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: John T. Rhines Co., 3015 12th St. N.E., D.C. 20017

25a. DATE REC'D. BY REGISTRAR: FEB 08 1989 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. SEE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

1- FOR STATE REGISTRAR UNKNOWN #89-20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005903

1. DECEASED NAME (TYPE OR PRINT): FIRST DONALD; MIDDLE EVERETT; LAST PARRELLA

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 2 DAY 13 YEAR 1989 — 2b. HOUR M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: Oct 6 1957 — 6. AGE (IN YEARS LAST BIRTHDAY): 32 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: 2 13 1989 — 2d. HOUR 2:25 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [XX]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.

10. CITY OR TOWN OF DEATH: Clinton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): road-10100 Dangerfield Rd. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic — 12b. KIND OF BUSINESS OR INDUSTRY: Auto

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Ft Washington — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 11009 Old Fort Rd

14. FATHER'S NAME: FIRST Joseph; MIDDLE A.; LAST Parrella

15. MOTHER'S MAIDEN NAME: FIRST Patricia; MIDDLE Lee; LAST Adkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): ----------

16b. SOCIAL SECURITY NO.: Unknown

17. INFORMANT ADDRESS: David Adkins/uncle/same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound to chest
Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: 1 PM 2-13- 1989 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject shot

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] — 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.): road — 21f. LOCATION STREET: 10100 Dangerfield Rd. CITY OR TOWN: COUNTY: Prince George's STATE: MD

22a. I certify that I took charge of the remains described above held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. — TITLE (SPECIFY) MEDICAL EXAMINER: Acting Deputy Chief — DATE SIGNED: 2-13-89

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. — ADDRESS: 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Feb 17 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Washington National — 23d. LOCATION CITY OR TOWN: Suitland COUNTY: PG STATE: MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: Robert E Wilhelm Funeral Home Suitland MD

25a. DATE REC'D. BY REGISTRAR: FEB 21 1989 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

122939 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05904
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	DANIEL / A. / PERRY	2a. DATE OF DEATH MONTH DAY YEAR	02 10 89	2b. HOUR	5 30PM M
3. SEX	Male	4. RACE	Black	5. DATE OF BIRTH MONTH DAY YEAR	12 7 46
6. AGE (IN YEARS LAST BIRTHDAY)	42 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Washington, DC	7b. CITIZEN OF WHAT COUNTRY?	United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH	CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PRINCE GEORGES HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Counselor
12b. KIND OF BUSINESS OR INDUSTRY	Private				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	PG	13c. CITY OR TOWN	Cheverly
13d. INSIDE CITY LIMITS? YES [X] NO [ ]		13e. STREET ADDRESS	3116 Cheverly Avenue 20785		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Haywood / / Perry	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Magnolia / / Bullock		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	Viet Nam	16b. SOCIAL SECURITY NO.	579-58-8078
17. INFORMANT ADDRESS	Deatrie Perry/3116 Cheverly Ave. Cheverly, Maryland				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) SYSTEMIC INFECTION
DUE TO, OR AS A CONSEQUENCE OF (c) AIDS AND BONE MARROW FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 88 to 2/10 19 89, that (I) (we) last saw the deceased alive on 2/10 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] 22c. DATE SIGNED Feb. 11, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ophnell Cumberbatch

22e. ADDRESS 601 60th Pl. Fairmont Hghts., MD 20743

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	18 Feb 89	23c. NAME OF CEMETERY OR CREMATORY	Ft. Lincoln Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Bladensburg PG Maryland				
24. FUNERAL DIRECTOR NAME / ADDRESS	JB Jenkins FH/7474 Landover RD. Landover, MD	25a. DATE REC'D BY REGISTRAR	FEB 13 1989	25b. REGISTRAR'S SIGNATURE	[signature]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05905
REG. NO.

024787 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place all three cardboard papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial or cremation. removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Johnson	MIDDLE: W.	LAST: Phares	2a. DATE OF DEATH MONTH DAY YEAR: 02 14 89		2b. HOUR: 6:20 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept 20 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sheet Metal Worker	12b. KIND OF BUSINESS OR INDUSTRY: Sheet Metal	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: Temple Hills	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 5914 St Moritz Drive 20748	
14. FATHER'S NAME FIRST: Charles	MIDDLE	LAST: Phares	15. MOTHER'S MAIDEN NAME FIRST: Ida	MIDDLE	LAST: Brent
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 578 24 9337	17. INFORMANT ADDRESS: Catherine Phares/wife/same as #13		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immed
DUE TO, OR AS A CONSEQUENCE OF (b): Bilateral Pneumonitis — 1 wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Prev. Cardio Pulmonary Arrest-Sleepapea C.V.A. & deafness

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan 10, 19 89 to Feb 14, 19 89, that (I) (we) last saw the deceased alive on Feb 14, 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kelvin Minchin — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KELVIN L. MINCHIN — 22e. ADDRESS: 6180 OXON HILL RD OXON HILL MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb 18 1989	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill	23d. LOCATION CITY OR TOWN: Suitland	COUNTY: PG STATE: MD
24. FUNERAL DIRECTOR NAME: Robert E Wilhelm Funeral Home ADDRESS: Suitland MD		25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

025094 MAR - 9 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 059065 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ALBERT — MIDDLE: Bailey — LAST: PHELPS

2a. DATE OF DEATH — MONTH: 2 — DAY: 16 — YEAR: 1989

2b. HOUR: 7-28 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH — MONTH: 6 — DAY: 22 — YEAR: 1914

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George County MD.

10. CITY OR TOWN OF DEATH: Laurel

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor Trans.

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Prince George — 13c. CITY OR TOWN: Laurel — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 7907 Brooklyn Bridge Rd 20707

14. FATHER'S NAME — FIRST: Lewis — MIDDLE — LAST: Phelps

15. MOTHER'S MAIDEN NAME — FIRST: Mae — MIDDLE — LAST: Hill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217 -09 -9278

17. INFORMANT: Richard Phelps — ADDRESS: 10790 West Crestview Dr Laurel, Maryland 20707

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIORESPIRATORY FAILURE.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): PULMONARY Metastais renal cancer.

DUE TO, OR AS A CONSEQUENCE OF (c): CLEAR CELL CARCINOMA Right Kidney

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPERTENSION.

19a. DATE OF OPERATION: June 1988

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/14/ 19 88 to 2/16/ 19 89, that (I) (we) last saw the deceased alive on 2/15/ 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE: Abdul Naxeem — DEGREE: M.D — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABDUL NAXEEM, M.D

22e. ADDRESS: 3450 FORT MEADE ROAD LAUREL, M.D. 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb 20, 1989

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

23d. LOCATION — CITY OR TOWN: Highland — COUNTY — STATE: Maryland

24. FUNERAL DIRECTOR — NAME: Donaldson Funeral Home P.A. — ADDRESS: Laurel, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 27 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-1660M 1/73
(VR A 15 (4))

021712 FEB - 6 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05907 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the continuation pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
MARY		PHILL	02	01	89	11 33AM M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Bl.	Jan 29, 1928	61 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Guyana	U.S.A.		PRINCE GEORGES COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER	Domestic	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P. G.	Suitland	YES XX NO	2015 Spaulding Dr. 20746

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Clifford		Phill	Mary		January

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		069-60-9198	Paullette P. Phill	2015 Spaulding Ave. Suitland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE — YEARS

DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS — YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPOGLYCEMIC STUPOR

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/27/89 to 2/1/89, that (I) (we) last saw the deceased alive on 1/31/89 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
	MD	X	2/1/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
P Shekar MD	7500 Greenway Ctr Dr Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 10, 1989	LaPenteer	Georgetown, Guyana

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Sam Butler Funeral Service	716 Kennedy St. N. W. Washington, DC	FEB 3 1989	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

022861 FEB 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 059 08 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Ann	MIDDLE: Joelena	LAST: PIERCE	2a. DATE OF DEATH MONTH DAY YEAR: February 6, 1989	2b. HOUR: 2:36A M	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: May 11, 1950	6. AGE (IN YEARS LAST BIRTHDAY): 38 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Florida	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Doctor's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Publishing Analyst, Cable News	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. Geo.	New Carrollton	YES ☒ NO ☐	5418 - 85th Avenue, 20784

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Joel Pierce	Ethel Moore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS	
No	267-84-7573	Valencia Drumgo, 5418-85th Ave. New Carrollton, MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIORESPIRATORY ARREST	2 HRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	FULMINANT SEPSIS	3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	GANGRENOUS BOWEL	3 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: INTESTINAL OBSTRUCTION, ACUTE RENAL FAILURE, CONSUMPTIVE COAGULOPATHY

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/3/89 + 2/5/89	INTESTINAL GANGRENE	YES ☒ NO ☐	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from FEB 3, 19 89, to FEB 6, 19 89, that (I) (we) last saw the deceased alive on FEB 5, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Napoleon C. Marcelo, Jr.	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/8/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): NAPOLEON C. MARCELO	22e. ADDRESS: 5632 ANNAPOLIS RD #12 BLADENSBURG, MD 20710	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/11/89	Restlawn Memorial Park	Jacksonville, Florida

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
McGuire Funeral Service, 7400 Georgia Ave. N.W. Washington, DC	FEB 13 1989	Lia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025089 MAR - 9 89 OR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 9 - 0 5 9 0 9 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): John Wesley Pinkney
2a. DATE OF DEATH: 2 14 89
2b. HOUR: 6:10 PM
3. SEX: Male
4. RACE: Black
5. DATE OF BIRTH: 7 14 13
6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: US
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.
10. CITY OR TOWN OF DEATH: Clinton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Pineview Manor Ext. Care Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Prince Geo
13c. CITY OR TOWN: Marlow Hts.
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 3940 Bexley Place 20746

14. FATHER'S NAME: Thomas Pinkney
15. MOTHER'S MAIDEN NAME: Mattie Skinner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 215 18 0553
17. INFORMANT: Janie Pinkney ADDRESS: SAA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Prostate Carcinoma
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M. Mostoller DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT):
22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/ 18/ 89
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem
23d. LOCATION CITY OR TOWN COUNTY STATE: Clinton P.G.Co., MD

24. FUNERAL DIRECTOR NAME ADDRESS: Martell Adams, Aquasco Md 20608
25a. DATE REC'D. BY REGISTRAR: FEB 24 '89
25b. REGISTRAR'S SIGNATURE: Juha Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

022320 FEB 10 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 059 10
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	MARIA Catharine PLACANICA
2a. DATE OF DEATH MONTH DAY YEAR	Feb. 8 - 1989
2b. HOUR	3:50 AM
3. SEX	FEMALE
4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	4 12 91
6. AGE (IN YEARS LAST BIRTHDAY)	97 YRS.
IF UNDER 1 YEAR MONTHS DAYS	
IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	ITALY
7b. CITIZEN OF WHAT COUNTRY?	U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE GEORGE MD.
10. CITY OR TOWN OF DEATH	ADELPHI
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Hill HAVEN N. Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker
12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	PG
13c. CITY OR TOWN	Hyattsville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS	2402 Lewisdale Drive 20783
14. FATHER'S NAME FIRST MIDDLE LAST	SANTO LAVORATA
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	TERESA FRANCO
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	N/A
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	213 74 1194
17. INFORMANT ADDRESS	Same as 13E Joseph Procaccino (son in law)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
DUE TO, OR AS A CONSEQUENCE OF (b) OLD AGE
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from OCTOBER, 19 88, to PRESENT, 19 ____, that (I) (we) last saw the deceased alive on 2-8-, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Chas Benner MD		2-8-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	
CHARLES BENNER MD	11161 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY STATE
Burial	2/11/89	Gate of Heaven	S.S.	Mont. Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hines Rinaldi (TSD) 11800 New Hamps.	FEB 09 1989	Julia Davidson-Randall

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

023021 FEB 15 89 Items18a,22a per M.E. FilmG650 4/28/89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR CG

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 059111

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Franklin	Andrew	Pollitt

2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH 2 DAY 5 YEAR 19 89 — 2b. HOUR

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 1 YR. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Male	White	Jan. 28, 1930	59 YRS.				

2c. DATE PRONOUNCED DEAD MONTH 2 DAY 5 YEAR 19 89 — 2d. HOUR 6:39 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Forestville	Regency Nursing Home	Carpenter	Various Companies

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Mt. Rainier	YES X NO ☐	4027 36th Street 20712

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Kenneth	A.	Pollitt	Margaret		Hearn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (TYPE OR PRINT)	MAILING ADDRESS (STREET OR R.F.D., CITY OR TOWN, STATE)
Yes-Army	Korean	213-22-7343	(Sister) Jeane P. Robison	3802 Newton Street Colmar Manor, Md 20722

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Julia C. Goodin M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-7-89

VC EXAMINER'S NAME (TYPE OR PRINT) Julia C. Goodin,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	02/09/89	Metropolitan Crematory	Alexandria Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR FEB 9 '89 — 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH ITEMS FROM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP356 DHMH - 17 (VR A15 ME (5))

024989 MAR -8 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 059 12
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Shirley	Marion	Poole	2 - 8 - 89	12 40 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	August 4, 1928	60 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D.C.	U.S.A.		Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Riverdale	Leland Memorial Hospital	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P.G.	Brentwood	YES X NO	3709 Taylor Street 20722

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John O.	Murphy		Ora	O.	Goldsmith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT
No		577-36-7410	(Husband) 3709 Taylor Street William W. Poole, Sr Brentwood, Md. 20722

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Hypotension

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Renal Failure Sacral Decubitus ulcer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES / NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/25/88, 19 88, to 2-8-, 19 89, that (I) (we) last saw the deceased alive on 2-8- 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Rakesh Arora	MD	ATTENDING PHYSICIAN / MEDICAL DIRECTOR X / STAFF PHYSICIAN	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RAKESH ARORA, M.D., P.A.	14300 Gallant Fox Lane, Suite 222 Bowie, Maryland 20715

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY / STATE
Burial	02/13/89	Arlington National Cem.	Arlington	Virginia

14300 Gallant Fox Lane Suite 222 BOWIE, MD 20715

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A.	4739 BAltimore Avenue Hyattsville, Maryland 20781	FEB 17 '89	Julia Davidson Parker

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024908 MAR -8 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05913 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Gladys	V.	PORTER	February 2, 1989	2:50P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Black	08 06 1889	99 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	Doctors' Hospital		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	prince Geo	Brandywine	YES ☒ NO ☐	12001 North Keys Rd. 20613

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Richard	A.	Johnson	Carrie		Ford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		213 74 7296	Gladys J. Hall	2903 East Ave. Forestville MD. 20747

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	1 hour
DUE TO, OR AS A CONSEQUENCE OF (b)	Endocrine Cancer	2 mos.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cardiac Arrest, Arthritis, Alzheimer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 1/1, 19 89, to 2/1, 19 89, that (I) (we) last saw the deceased alive on 2/1, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR ☒ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
Jack C Meshel	MD		2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jack C Meshel	5806 Baltimore Ave. Hyattsville MD 20781

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/7/89	Gibbons UMC Cem	Brandywine, P.G. Co., MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Martell Adams Aquasco Md 20608	FEB 15 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023037 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 059 14
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
MARY	S.	PORTER	01	31	89	3.15A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Female	Black	Feb. 29, 1920	68 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
D.C.	U.S.A.		PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	Nursing Ass't.	Nursing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	P.G.	Cap. Hts.	YES ☒ NO ☐	839 Eastern Ave.

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph		Proctor	Mary		Briscoe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		579-22-5625	Crystal Thompson-Ft. Wash., Md.	8201 Bernard Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) ISCHEMIC CARDIOMYOPATHY

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa
Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 28 Jan, 19 89, to 31 Jan, 19 89, that (I) (we) last saw the deceased alive on 30 JAN 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
M.L. Schwartz	MD		2 Feb 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MICHAEL SCHWARTZ	7500 Hanover Pkwy #103 Greenbelt MD. 20770

23a. BURIAL, CREMATION, REMOVAL (CIRCLE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
	2/4/89	Mt. Olivet Cem.	Wash.	D.C.	

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
H.S. Washington & Sons	4925 Benning Rd. N.E.	FEB 15 1989	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

Female dlack Feb. 29,1920 68

D.C. U.S.A. x

Nursing Ass't.Nursing

Md. P.O. Dep. Hts. x 839 Eastern Ave.

Joseph Proctor Mary Briscoe

No 479-22-5625 Crystal Thompson-Ft. Wash.,Md. 8201 Bernard Dr.

022338 FEB 1 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 025915

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE PAGE 1 CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST					2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	MONTH	DAY	YEAR	2b. HOUR
	Albert		Powell						2-5-89			PM
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 1 YR. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD	2-5-	19 89	2d. HOUR 10:50 PM
Male	Black		02	06	06	82 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐					9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.									Prince Georges County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Georges General Hospital				Retired								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE	13b. COUNTY	13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS							
Maryland	A.A.	Edgewater					4344 [illegible] Lansdale Road							
14. FATHER'S NAME	FIRST	MIDDLE	LAST				15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST				
	Burnett		Robinson					Joan		Powell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS				
NO						213-22-0165-A	Mary I. Powell 4344 Lansdale Road			Edgewater, Md. 21037				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		☒ YES ☐ NO

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	7:13PM 1-31-89	Pedestrian struck by auto

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☒	road	Lansdale & Hopkins Roads,	West River,	Anne Arundel County,	MD

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF M.D. Julia C. Goodin M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-7-89

vc EXAMINER'S NAME (TYPE OR PRINT) Julia C. Goodin, M.D. ADDRESS 111 Penn street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2-11-89	Chews Church Cemetery	Owensville	A.A	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wm. Reese & Sons Mortuary P.A.,	Annapolis, Md. 21401	FEB 10 1989	Julia Davidson-Landers

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

Ltr. #'s18a, 22a per med Film G649 3/14/89cg

FOR REGISTRAR 2-10-89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 059116

02-29-15

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE REGISTRAR, DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Sherry	MIDDLE: Lynn	LAST: Presgraves	2a. DATE OF DEATH KNOWN [XX] ESTIMATED [ ] MONTH: 2- DAY: 4- YEAR: 19 89	2b. HOUR	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 7-22-1971	6. AGE (IN YEARS LAST BIRTHDAY): 17 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-4- 19 89	2d. HOUR: 5:31 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.SA	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.		
10. CITY OR TOWN OF DEATH: Bowie	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bowie Health Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student	12b. KIND OF BUSINESS OR INDUSTRY: School		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. George's	13c. CITY OR TOWN: Bowie	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 2703 Aloha Place	20716
14. FATHER'S NAME FIRST: Virgil	MIDDLE: B.	LAST: Presgraves, III	15. MOTHER'S MAIDEN NAME FIRST: Ernestine	MIDDLE:	LAST: Davis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): --------	16b. SOCIAL SECURITY NO.: 218-80-9838	17. INFORMANT: Virgil B. Presgraves, III	ADDRESS: same as #13		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Seizure disorder
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Charles P. Kokes M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED: 2-5-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes,M.D. ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-9-1989	23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE: Silver Spring, Montgomery, Md	
24. FUNERAL DIRECTOR ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

07/84 25M BP 348 DHMH - 17 (VR A15 ME (5))

022592 FEB 13 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 05917

1. DECEASED NAME (TYPE OR PRINT): FIRST Josephine MIDDLE B. LAST Preziotti
2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 2 YEAR 1989
2b. HOUR M
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: MONTH Mar. DAY 13 YEAR 1926
6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.
IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 2 YEAR 1989 HOUR 1148 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.
10. CITY OR TOWN OF DEATH: Clinton
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital Cntr.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): homemaker
12b. KIND OF BUSINESS OR INDUSTRY: home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Pr.George's
13c. CITY OR TOWN: Temple Hills
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 5304 Acorn Drive

14. FATHER'S NAME: FIRST Richard MIDDLE LAST Boland
15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE Elizabeth LAST Hughes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): n/a
16b. SOCIAL SECURITY NO.: 199-16-5137
17. INFORMANT: husband ADDRESS: Arnold Preziotti same as 13 a-e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2-5-89

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial
23b. DATE Feb. 6, 1989
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
23d. LOCATION CITY OR TOWN Clinton, P.G. COUNTY STATE MD

24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 6633 Old Alexander Ferry Rd., Clinton, MD20735
25a. DATE REC'D. BY REGISTRAR FEB 09 1989
25b. REGISTRAR'S SIGNATURE Julia Dawson-Kendall

TO MEDICAL EXAMINER: THE CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP
DHMH - 17 (VR A15 ME)

023304 FEB 21 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05918
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Frank	Nelson	Proctor	02 09 89	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	Caucasian	04 15 02	86 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	U.S.A.		Prince George's MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Temple Hills	6611 Summerhill Rd. 20748	Division Chief	Federal Govt.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS / ZIP CODE
Maryland	P. G.	Temple Hills		6611 Summerhill Rd. 20748
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	Lee	Proctor Sr.	Christina		Mills
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	579-01-4442	Donald N. Proctor	~~6609 Summerhill Rd.~~ Temple Hills, Md 20748

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic obstructive pulmonary
DUE TO, OR AS A CONSEQUENCE OF (b) disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-11 19 88 to Feb 19 89 that (I) (we) last saw the deceased alive on May 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE M Taleghani DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Taleghani 22e. ADDRESS 4467 Old Branch Ave Temple Hills MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/13/89	Cedar Hill Cemetery	Suitland Prince George's Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc.	6633 Old Alexander Ferry Rd Clinton, Md 20735	FEB 16 1989	Julia Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05919
REG. NO.

023301 FEB 21 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or removal.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT): FIRST Mary MIDDLE C LAST Pulley
2a. DATE OF DEATH: MONTH 2 DAY 11 YEAR 89
2b. HOUR: 7:25 PM
3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: MONTH NOV. DAY 2 YEAR 1917
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Arkansas
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George County MD.
10. CITY OR TOWN OF DEATH: Clinton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland 13b. COUNTY: Pr. Geo. 13c. CITY OR TOWN: Temple Hills 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE: 5825 Fisher Rd. #202 20748

14. FATHER'S NAME: FIRST Prince MIDDLE Oliver LAST Ledbetter
15. MOTHER'S MAIDEN NAME: FIRST Bertha MIDDLE Tenola LAST Richardson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): —
16b. SOCIAL SECURITY NO.: 514-09-4755
17. INFORMANT: Donna Cunningham ADDRESS: Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary
DUE TO, OR AS A CONSEQUENCE OF (b): Hospital Acquired Pneumonia.
DUE TO, OR AS A CONSEQUENCE OF (c): Dysphagia, HBP, DM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-24- 1989 to 2-11 1989, that (I) (we) last saw the deceased alive on 2-11- 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2-12-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABUL HASAN ANSARI
22e. ADDRESS: 8926 Old Piscataway Rd #101 Clinton Md. 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-15-89
23c. NAME OF CEMETERY OR CREMATORY: FOREST LAWN
23d LOCATION CITY OR TOWN: Los Angeles COUNTY: L.A. STATE: California

24. FUNERAL DIRECTOR NAME: Lee Funeral Home ADDRESS: 6633 Old Alexander Ferry Rd. Clinton, Md.
25a. DATE REC'D. BY REGISTRAR: FEB 16 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

024923 MAR 8 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05920 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
CHARLES	S.	PUMPHREY	2/5/89			4.00A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	Sept	24	1922	66 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	United States		PRINCE GEORGES MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER	CLERK	US Govt Senate OFFICE Bldg.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	PRINCE GEORGE	District Hghts	YES ☒ NO ☐	7220 Kipling PARKWAY 20747

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
EIMER		PumphREY	Elsie		GRAY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	World War II	578-20-1364	Mary Pumphrey - SAME AS #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis

DUE TO, OR AS A CONSEQUENCE OF (c) H.I.V. Positive

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/1 19 89 to 2/5 19 89 that (I) (we) last saw the deceased alive on 2/4 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
	MD		2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	Feb 7 1989	Maryland VETERANS	Cheltenham	P.G.	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert E. WILHELM FUNERAL HOME	Suitland MD	FEB 10 '89	Julia Davidson-Randall

(5) BP

DHMH - 16 60M 7/84
(VRA 15, 4)

021932 FEB 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 059211

1. DECEASED NAME (TYPE OR PRINT): FIRST Horace MIDDLE J. LAST Randall Jr.

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 1 YEAR 19 89 — 2b. HOUR M

3. SEX: Male — 4. RACE: Black — 5. DATE OF BIRTH: MONTH 1 DAY 27 YEAR 29 — 6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 1 YEAR 19 89 — 2d. HOUR 6:12 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Telephone Tech. — 12b. KIND OF BUSINESS OR INDUSTRY: AT&T Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Landover — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 3410 Edwards Street

14. FATHER'S NAME: FIRST Horace MIDDLE J. LAST Randall Sr.

15. MOTHER'S MAIDEN NAME: FIRST Ethel MIDDLE Mae LAST McShan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 164-22-9983

17. INFORMANT ADDRESS: Lillian P.Randall 3410 Edwards St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Asthma

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 2-2-89

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Feb.7.89 — 23c. NAME OF CEMETERY OR CREMATORY: Sylvan Hgts.Cem — 23d. LOCATION CITY OR TOWN: Union Town COUNTY: Pa. STATE

24. FUNERAL DIRECTOR NAME AND ADDRESS: HUNT FUNERAL HOME 2801 7TH ST. N.E. DC — 25a. DATE REC'D. BY REGISTRAR: FEB 6 1989 — 25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 PART 1 (a). PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024804 MAR -7 '89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05922 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
LOVELLA	ANNE	RATCLIFF	02	09	89	3 28PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Caucasian	April 10, 1934	54 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Texas	U.S.A.		PRINCE GEORGES COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER	Secretary	Private Industry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Queen Annes	Queenstown	YES ☒ NO ☐	Route 1 Box 224, C-3 Somerset Court 21658

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Melvin	Earl	George	Elaine		Whitney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Unavailable	Virginia Moore (Daughter) Rt. 1 Box 224, C-3 Somerset Court Queenstown, Md. 21658

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) VARICEAL BLEED — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS — YEARS

DUE TO, OR AS A CONSEQUENCE OF (c) HYPERVITAMINOSIS A — YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from 1/14 19 89 to 2/9 19 89 that I (we) last saw the deceased alive on 2/8 19 89 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
	MD		2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
[illegible] MD	7500 Greenway Ctr Dr Greenbelt Md 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	02/19/89	Metropolitan Crematory	Alexandria / Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A.	4739 Baltimore Avenue Hyattsville, Md. 20781	FEB 21 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The [illegible] the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The permit may not remove cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

(24)

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

023154 FEB 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05923 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SADIE MIDDLE: Reynolds LAST: RICE				2a. DATE OF DEATH MONTH DAY YEAR: 2 · 13 · 89	2b. HOUR: 1.45 P M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 2 27 14	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE Georges Co MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): So. MARYLAND Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: N/A		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: Upper Marlboro	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS: 100 Chartsey Street 20772	
14. FATHER'S NAME FIRST: John MIDDLE LAST: Reynolds		15. MOTHER'S MAIDEN NAME FIRST: Pearl MIDDLE LAST: Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 220-05-4095	17. INFORMANT ADDRESS: Rodney Rice/100 Chartsey St. Upper Marlboro, Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mins

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure — 3 days

DUE TO, OR AS A CONSEQUENCE OF (c): Advanced Arteriosclerotic cardio-vascular disease — 20 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Chronic Renal Failure. Hepatocellular Damage Secondary to Prev. Hepatitis Under A

19a. DATE OF OPERATION: DNA	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: DNA	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): DNA	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET: DNA CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 83 to 2/13 19 89, that (I) (we) last saw the deceased alive on 2/13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Richard A. Farson, MD.	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Richard A. Farson, MD.	22e. ADDRESS: 9401 Indianhead Hwy Ft Wash., Md. 20744	#360

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 17 Feb 89	23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park	23d. LOCATION CITY OR TOWN: Landover	COUNTY: PG STATE: Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: JB Jenkins FH/7474 Landover Rd. Landover, MD	25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 1650M 1/81 (VRA 15, 4)

024913 MAR -8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 052924

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: E.	LAST: Riley	2a. DATE OF DEATH MONTH DAY YEAR: February 16, 1989	2b. HOUR: 9:15A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 7 21 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Pineview Manor Ext. Care Facility	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. Georges	13c. CITY OR TOWN: Oxon Hill	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 101 Panorama Dr. 20745	
14. FATHER'S NAME FIRST: Edward	MIDDLE	LAST: Garrett	15. MOTHER'S MAIDEN NAME FIRST: Sarah	MIDDLE: I.	LAST: Devlin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-16-7944	17. INFORMANT ADDRESS: Alice A. Agrafiotis as in item 13		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Dementia, Multiple infarct dementia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~the physician~~) attended the deceased from 12/1 19 88 to 2/16 19 89, that ~~he~~ (we) last saw the deceased alive on 2/16 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, ~~he~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: R.A. McConnaughy MD — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): R.A. McConnaughy M.D.

22e. ADDRESS: 11418 Livingston Rd. Ft. Washington, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-18-89	23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem.	23d. LOCATION CITY OR TOWN: Clinton	COUNTY: P.G. STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

023650 FEB 23 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05925 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KATHREEN	MIDDLE: SUNWALL	LAST: ROCKWELL	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 11 1989
2b. HOUR: 6:50 p M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: November 11, 1895	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Minnesota	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
10. CITY OR TOWN OF DEATH: Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Malcolm Grow AFB Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: Washington, DC	13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS: Boling AFB 65 Westover Avenue, SW / 20332			
14. FATHER'S NAME FIRST: Gustaf	MIDDLE: F.	LAST: Sunwall	15. MOTHER'S MAIDEN NAME FIRST: Anne MIDDLE: LAST: Kelly
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 475-24-2168	17. INFORMANT: Anthony Rockwell, ADDRESS: 3337 Ivy Lane Minneapolis, MN 55416

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital attended the deceased from 08 Feb 19 89 to 11 Feb 19 89, that (I) (we) last saw the deceased alive on 11 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 11 FEB 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DARRYL C HUNTER, CAPT, USAF, MC

22e. ADDRESS: MGMC, ANDREWS AFB, MD 20331-5300

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-16-89	23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Minneapolis, Minnesota
24. FUNERAL DIRECTOR NAME / ADDRESS: Gill Brothers' Funeral Chapel 55419 5801 Lyndale Avenue, South, Minneapolis, MN	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Celia Knudsen Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025137 MAR 1-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5926

1. DECEASED NAME (TYPE OR PRINT): FIRST Tracey MIDDLE M. LAST Rodgers

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 2 DAY 18 YEAR 1989 — 2b. HOUR M

3. SEX: MALE — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH JAN DAY 30 YEAR 1964 — 6. AGE (IN YEARS LAST BIRTHDAY): 25 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 18 YEAR 1989 — 2d. HOUR 2:33 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): HAWAII — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☒ XX WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.

10. CITY OR TOWN OF DEATH: Camp Springs — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AndrewsAFB Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): WAREHOUSEMAN — 12b. KIND OF BUSINESS OR INDUSTRY: LIQUOR

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. — 13b. COUNTY: PRINCE GEO. D — 13c. CITY OR TOWN: IST.HGHTS. — 13d. INSIDE CITY LIMITS? YES ☒ XX NO ☐ — 13e. STREET ADDRESS: 6032 PARKLAND CT. #2 20747

14. FATHER'S NAME: FIRST THEODORE MIDDLE RODGERS LAST JR.

15. MOTHER'S MAIDEN NAME: FIRST DOROTHY MIDDLE WALKER LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217 02 1047

17. INFORMANT: THEODORE RODGERS FATHER — ADDRESS: 1921 BROOKS DR.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shotgun wound of back
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. 1:45 XX MONTH 2 DAY 18 YEAR 1989 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject shot

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): parking lot — 21f. LOCATION STREET: 6619 Atwood St, CITY OR TOWN: District Hgts, COUNTY: P.G. Co., STATE: MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐,

ACTUAL SIGNATURE: Margarita A. Korell — TITLE (SPECIFY): M.D. Assistant MEDICAL EXAMINER — DATE SIGNED: 2/18/89

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 Penn St. Balto.MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: FEB 25,1989 — 23c. NAME OF CEMETERY OR CREMATORY: NATIONAL — 23d. LOCATION CITY OR TOWN: SUITLAND, COUNTY: MD STATE:

24. FUNERAL DIRECTOR: RALPH WILLIAMS FUNERAL SVC. 719 KENNEDY STREET N.W. WASHINGTON D.C. 20011

25a. DATE REC'D. BY REGISTRAR: FEB 22 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

(5)

021691 FEB-6 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR 1-89 AKA Callie Ross

REG. NO. 89 05927

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	CALLIE Carolyn ROSS
2a. DATE OF DEATH MONTH DAY YEAR	2 01 89
2b. HOUR	4:20 P.M.
3. SEX	Female
4. RACE	Negro
5. DATE OF BIRTH MONTH DAY YEAR	April 20, 1934
6. AGE (IN YEARS LAST BIRTHDAY)	54 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	
IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Elkin, N.C.
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE GEORGES MD.
10. CITY OR TOWN OF DEATH	CLINTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Southern Maryland Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Maid
12b. KIND OF BUSINESS OR INDUSTRY	Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	
13a. STATE	Maryland
13b. COUNTY	Prince Geo.
13c. CITY OR TOWN	Capital Heights
13d. INSIDE CITY LIMITS?	NO [ ] Yes
13e. STREET ADDRESS / ZIP CODE	5206 Cumberland Street 20743
14. FATHER'S NAME FIRST / MIDDLE / LAST	Shelton Foster
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Mary Etta Bowles
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO
16b. SOCIAL SECURITY NO.	194-22-3433
17. INFORMANT ADDRESS	Lee A. Ross, Husband. 5206 Cumberland Street, Capital Heights 20743

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	1/21/89 Pacemaker Insertion
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	Slow heart rate
20a. AUTOPSY?	YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	[ ]
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/21 19 88, to 2/1/89 19 ____, that (I) (we) last saw the deceased alive on 2/1 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	
DEGREE	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED	2/1/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	L. Berwa, M.D.
22e. ADDRESS	1300 Mercntile Lane, 134, Landover, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY / STATE
Burial	Feb. 7, 1989	Lincoln Memorial Cemetery	Suitland	Maryland

24. FUNERAL DIRECTOR NAME: W.H. Bacon Funeral Home Inc. ADDRESS: 3447-14th Street, N.W. Washington, D.C.

25a. DATE REC'D. BY REGISTRAR: FEB 3 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP____

DHMH - 16 50M 4/83 (VRA 15, 4)

024977 MAR -8 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05928 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last	Darlene K. ROSS	2a. DATE OF DEATH Month / Day / Year	February 8, 1989
		2b. HOUR	3:56 AM
3. SEX	FEMALE	4. RACE	WHITE
5. DATE OF BIRTH Month / Day / Year	AUGUST 15, 1943	6. AGE (IN YEARS LAST BIRTHDAY)	45 YRS
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE GEORGE'S COUNTY MD.
10. CITY OR TOWN OF DEATH	LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	DOCTOR'S HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	ADMINISTRATIVE AIDE	12b. KIND OF BUSINESS OR INDUSTRY	P.G. COUNTY GOV'T.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	P.G. CO.	GREENBELT	YES ☒ NO ☐	7724 HANOVER PARKWAY #101/20770

14. FATHER'S NAME First / Middle / Last	MERLE O. McCLURE	15. MOTHER'S MAIDEN NAME First / Middle / Last	GLADYS C. BAILEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	NONE
16b. SOCIAL SECURITY NO.	206-34-8380	17. INFORMANT ADDRESS	CHARLES ROSS (HUSBAND) SAME AS #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure	3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia	7 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	Metastatic Colon Cancer	1 1/2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 15 Nov 88 to 8 Feb 89, that (I (we) last saw the deceased alive on 8 Feb 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Thomas A. Bensinger	MD		2/8/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Thomas A. Bensinger MD	22e. ADDRESS	7525 Greenway Center Dr. Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	BURIAL	23b. DATE	FEB. 10, 1989	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
23d. LOCATION CITY OR TOWN / COUNTY / STATE	SUITLAND, P.G. CO., MARYLAND			
24. FUNERAL DIRECTOR NAME / ADDRESS	ROBERT E. WILHELM FUNERAL HOME SUITLAND, MD.	25a. DATE REC'D BY REGISTRAR	FEB 10 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 1650M 1/81 (VRA 15, 4)

022921 FEB 16 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005929

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the Secretary of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

1. DECEASED NAME (TYPE OR PRINT)	FIRST: DANTE	MIDDLE: A.	LAST: ROSS, Sr.		
2a. DATE OF DEATH	MONTH: 2	DAY: 2	YEAR: 89	2b. HOUR: 7:30 P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: March 24, 1917	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Ho.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Elec. Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Fed'l. Gov't.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr. Georges	13c. CITY OR TOWN: Suitland	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS / ZIP CODE: 6505 Pine Lane Dr. 20746	
14. FATHER'S NAME: FIRST Louis	MIDDLE	LAST Ross	15. MOTHER'S MAIDEN NAME: FIRST Marrietta	MIDDLE	LAST Valentino
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 134-12-2776	17. INFORMANT: Pauline R. Ross	ADDRESS: as in item 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [XX]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (the hospital) attended the deceased from 1 Sept 19 86, to 2 Feb 19 89, that (I) (not) last saw the deceased alive on 2/2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (not) (did) (did not) view the body after death.

22b. SIGNATURE: William J. Oetgen	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/2/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): William J. Oetgen M.D.	22e. ADDRESS: 3611 Branch Ave. Temple Hills, Md. 20748		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-6-89	23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery	23d. LOCATION CITY OR TOWN: Clinton	COUNTY: P.G. STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR: FEB 3 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

023478 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005930 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Charles	MIDDLE: John	LAST: Rozek, Sr.	2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] MONTH: 2 DAY: 16 YEAR: 19 89	2b. HOUR		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH Dec. DAY 22 YEAR 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 16 YEAR 19 89	2d. HOUR 8:35 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Hampshire	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.				
10. CITY OR TOWN OF DEATH: Bowie	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Route 301,N. of Pointer Ridge Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Self-employed	12b. KIND OF BUSINESS OR INDUSTRY: Automotive Parts Supplier				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Baltimore	13c. CITY OR TOWN: Towson	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 1204 Doves Cove Rd., 21204			
14. FATHER'S NAME: FIRST Abraham MIDDLE Joseph LAST Rozek			15. MOTHER'S MAIDEN NAME: FIRST Takla MIDDLE (Unknown by informant) LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 001-05-7442	17. INFORMANT: Esther L. Rozek, same as 13e.	ADDRESS			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Multiple injuries	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2-16-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Pedestrian struck by multiple vehicles	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road	21f. LOCATION STREET: Route 301,N. of Pointer Ridge Dr. CITY OR TOWN: Bowie, COUNTY: Prince Georges Co. STATE: MD	

22a. I certify that I took charge of the remains described above and on Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Mario F. Golle Jr. M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-17-89

VC EXAMINER'S NAME (TYPE OR PRINT): Mario F. Golle,Jr.,M.D. ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/21/89	Dulaney Valley Mem. Gardens	Timonium Balto. Md.

24. FUNERAL DIRECTOR NAME: Martin D. Lawson ADDRESS: 10 W. Padonia Rd.

25a. DATE REC'D. BY REGISTRAR: FEB 21 1989

25b. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall

15

07/84 25M BP

DHMH - T7 (VR A15 ME (5))

024592 MAR -3 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05931
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST JUANITA MIDDLE R. LAST RUMPF

2a. DATE OF DEATH: MONTH 02 DAY 18 YEAR 89

2b. HOUR 10.30 PM

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH: MONTH Feb DAY 1, YEAR 1934

6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH: CHEVERLY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bus Maintenance

12b. KIND OF BUSINESS OR INDUSTRY: Greyhound

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: md

13b. COUNTY: P.G

13c. CITY OR TOWN: Upper Marlboro

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 20772 223 Harry Truman Dr

14. FATHER'S NAME: FIRST John MIDDLE R. LAST Roberts

15. MOTHER'S MAIDEN NAME: FIRST Pauline MIDDLE Butler LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-98-7086

17. INFORMANT: Arthur A. Rumpf Sr. ADDRESS: same as # 13 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF: (b) Metastatic malignant Sarcoma

DUE TO, OR AS A CONSEQUENCE OF: (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: —

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/18/89 to 2/18/89, that (I) (we) last saw the deceased alive on 2/18/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: V. P. Chandra DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. Prem Chandra

22e. ADDRESS: 6501 Landover Rd, Cheverly Md 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-23-89

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem

23d. LOCATION: CITY OR TOWN Suitland COUNTY Maryland STATE

24. FUNERAL DIRECTOR: NAME Henry S. Washington's sons ADDRESS 4925 - Nannie H. Burroughs AVE. N.E.

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE

IMPORTANT. If Item 21 is marked yes, this case involves any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial (removal) permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

025075 MAR - 9 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05932 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: ROBERT H. SAMPSON				2a. DATE OF DEATH MONTH DAY YEAR: 02/16/89	2b. HOUR: 5:55 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 03/29/41	6. AGE (IN YEARS LAST BIRTHDAY): 47 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Plumber	12b. KIND OF BUSINESS OR INDUSTRY: Plumbing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: Camp Springs	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 7209 Old Branch Avenue 20748	
14. FATHER'S NAME FIRST / MIDDLE / LAST: George H. Sampson		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Avis E. Roberts			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): 1958-1962	16b. SOCIAL SECURITY NO.: 215-36-4355	17. INFORMANT ADDRESS: Betty Sampson (Wife) Same as # 13.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrhythmia	20 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	esophageal perforation	10 hours
DUE TO, OR AS A CONSEQUENCE OF (c)	tumoral involvement of mediastinum	weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: 2/15/89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: esophageal obstruction	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [X] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/15/89, 19__, to 2/16, 19 89, that (I) (we) last saw the deceased alive on 2/15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: T.P. Gage	DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/17/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): T.P. Gage	22e. ADDRESS: 10905 Ft. Washington Rd #406 Ft. Washington MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb/21/89	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, P.G. Co., Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Robert E. Wilhelm, Inc. Suitland, Maryland	25a. DATE REC'D. BY REGISTRAR: 3/23/89	25b. REGISTRAR'S SIGNATURE: Trichia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024752 MAR 7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05933
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for undertaker's burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: Illean	LAST: SAMUELS	2a. DATE OF DEATH MONTH: 02	DAY: 24	YEAR: 89
2b. HOUR: 5 00P M					
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: April 15,1928	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): homemaker	12b. KIND OF BUSINESS OR INDUSTRY: home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Charles	Waldorf	YES ☐ NO ☒	4001 Peach Dr. 20601

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Harry / Fitzgerald	Virginia / Goldsby

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	n/a	578-34-3268	daughter Donna Schena	3709 S. George Mason Dr. FallsChurch, VA 22041

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Hypoxic encepalopathy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Bronchiectasis, Malnutrition recurrent pneumonitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/4, 19 89, to 2/24, 19 89, that (I) (we) last saw the deceased alive on 2/24, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Gerardo M Gacad	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
GERARDO M GACAD	6492 Landover Rd Landover MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb.28,1989	MD Veterans Cemetery	Cheltenham, P.G. MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc. Old Alexander Ferry Rd., Clinton, MD 20735	MAR 01 '89	Julia Davidson-Randall

BP_____

DHMH - 16 60M 7/84 (VRA 15, 6) 6633

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

125098 MAR - 9 89

FOR 1 - STATE REGISTRAR

REG. NO. 89 05934

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: YOLANDA	MIDDLE: MARIE	LAST: SCARLATO	2a. DATE OF DEATH MONTH DAY YEAR: 02-25-89	2b. HOUR: 6 47AM M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 12-03-1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PRINCE GEORGE'S HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. George's	Cottage City	YES [X] NO [ ]	4142 Bunker Hill Road #615 20722

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Frank / / Petrone	Rose / / Tozzolo

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-------	579-10-7973	Nick M. Petrone Sebring, Florida 33872	4033 Thompson Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSSIBLE CARDIAC ARRYDLMIA
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE BRONCHOPNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-24 19 89, to 2-25 19 89, that (I) (we) last saw the deceased alive on 2-25 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M-S Nayar DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. M. NAYAR MD

22e. ADDRESS: 3717-38TH AVE, BRENTWOOD, MD 20722

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3-1-89	Mt. Olivet Cemetery	Washington, D.C.

24. FUNERAL DIRECTOR (NAME) AND ADDRESS: Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, Md. 20781

25. DATE REC'D. BY REGISTRAR: FEB 28 '89

26. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023295 FEB 21 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05935
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	MAURICE / / SCHULTZ	2a. DATE OF DEATH MONTH DAY YEAR	2.15.89	2b. HOUR	11.20 P.M.
3. SEX	Male	4. RACE	Caucasian	5. DATE OF BIRTH MONTH DAY YEAR	09 02 96
6. AGE (IN YEARS LAST BIRTHDAY)	92 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Nebraska	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE GEORGES CO MD				
10. CITY OR TOWN OF DEATH	CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	So. MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Engraver
12b. KIND OF BUSINESS OR INDUSTRY	Fed. Govt.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Virginia	Arlington	Arlington	YES ☐ NO ☒	2604 North 3rd St. 22201

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Unknown	Lidda / Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
Yes (IF YES, GIVE WAR OR DATES) WWII	230-50-6690	Elizabeth Ballard / 5816 Middleton Ct Camp Springs, Md20748

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lobar pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Dementia · Decubitus ulcers

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 22, 19 88, to Feb 15, 19 89, that (I) (we) last saw the deceased alive on Feb 15, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
J. Sanford Young	MD		2/16/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
J. Sanford Young MD	11701 Livingston Rd #101 Ft Wash. Md		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/18/89	Columbia Gardens Cem.	Arlington / Virginia
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc.	6633 Old Alexander Ferry Rd CLinton, Md 20735	FEB 16 1989	Julia Davidson-Randall

BP

DHMH - 16 50M) 1/81 (VRA 15, 4)

022042 FEB 8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05936
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BERTHA	MIDDLE: M. C.	LAST: SCOTT	2a. DATE OF DEATH MONTH: 2	DAY: 1	YEAR: 89	2b. HOUR: 1-35 AM
3. SEX: FEMALE	4. RACE: NEGRO	5. DATE OF BIRTH MONTH-DAY-YEAR: 10-22-24	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, D.	7b. CITIZEN OF WHAT COUNTRY?: C. USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): L.P. NURSE	12b. KIND OF BUSINESS OR INDUSTRY: BETHESDA NAV.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: P.G.	13c. CITY OR TOWN: FT. WASH.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 8002 CAREY BRANCH DR. 20744			
14. FATHER'S NAME FIRST: (UNKNOWN)	MIDDLE:	LAST:	15. MOTHER'S MAIDEN NAME FIRST: (UNKNOWN)	MIDDLE:	LAST:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 578-26-2682	17. INFORMANT: ANN S. GROOMS	ADDRESS: 8002 CAREY BRANCH DR. FT. WASH., MD. 20744			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Pulm. arrest, CHF — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): COPD & Advanced Emphysema

DUE TO, OR AS A CONSEQUENCE OF (c): Pancreatic Cancer, Anaplastic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-18-, 19 89, to 2-1-, 19 89, that (I) (we) last saw the deceased alive on 01-31-, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABUL HASAN ANSARI

22e. ADDRESS: 5022 Edgeware Rd #101 Clinton Md. 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/7/89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEMORIAL	23d. LOCATION CITY OR TOWN / COUNTY / STATE: LANDOVER, MARYLAND

24. FUNERAL DIRECTOR NAME: MORROW & WOODFORD, INC. ADDRESS: 1622 11TH. ST., NW WASH., DC 20001

25a. DATE REC'D. BY REGISTRAR: FEB 6 1989

25b. REGISTRAR'S SIGNATURE: [signature]

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

025079 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05937
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Violet MIDDLE P. LAST Sheppard

2a. DATE OF DEATH: MONTH Feb DAY 19 YEAR 1989

2b. HOUR 9:00 A.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Oct DAY 5 YEAR 1893

6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County

10. CITY OR TOWN OF DEATH: Clinton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN: Washington D

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS #5: 3901 Martin Luther King Ave

14. FATHER'S NAME: FIRST Steven MIDDLE LAST Vogan

15. MOTHER'S MAIDEN NAME: FIRST Lena MIDDLE LAST Bortz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: MD ADDRESS: Alice Talbott/500 Scarlett Oak Rd/LaPlata

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Glaucoma - OSTD - H. Uterus - Pleurisy - cholecystectomy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/26 19 88 to 2/19 19 89 that (I) (we) last saw the deceased alive on 2/19 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. M. Sam MD DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): REZA MOSTAFAVI

22e. ADDRESS: 9235 26th Ave md 20748

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb/22/89

23c. NAME OF CEMETERY OR CREMATORY: Washington National

23d. LOCATION: CITY OR TOWN Suitland COUNTY PG STATE MD

24. FUNERAL DIRECTOR: NAME Robert E Wilhelm Funeral Home ADDRESS Suitalnd MD

25a. DATE REC'D BY REGISTRAR: FEB 23 89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

4

DHMH - 1650M 1/81 (VRA 15, 4)

J24461 MAR 2 89

STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 005938
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
	BROCKIE	D.	SIMMONS		02	21	89	11.05P M

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	Caucasian	Oct. 1, 1912	76 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
North Carolina	U.S.A.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	Manager/ Maint.	Apartments

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Georges	Laurel	YES ☐ NO ☒	500 Prince George St. 20707

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Michael Arthur Simmons	Susie Leona Scott

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	228 03 9820	Geneva Simmons (wife)	Same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure - Acute	1wk
DUE TO, OR AS A CONSEQUENCE OF (b)	Status Post Pneumonectomy	14yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chronic Lymphocytic Leukemia, Gastrointestinal Bleed

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY (HOUR A.M. P.M. MONTH DAY YEAR 19)	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE)

22a. I certify that (I) (this hospital) attended the deceased from Feb 6, 19 89, to 21 Feb, 19 89, that (I) (we) last saw the deceased alive on 21 Feb, 19 89, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	MD		2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Thomas A. Benjamin	7525 Greenway Ctr. Dr. Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN, COUNTY, STATE)
Burial	25 Feb. 89	Odd Fellows Cemetery	Ivanhoe, Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Capitol Funeral Service,	Falls Church, VA	MAR 1 1989	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

Items18,22a Film Per M.E.4/5/89 CG

025.39

Mar-14-89

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05939 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED BY THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: James	MIDDLE: Allen	LAST: Sine	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐	MONTH: 2	DAY: 26	YEAR: 89	2b. HOUR: M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: 10	DAY: 17	YEAR: 88	6. AGE (IN YEARS LAST BIRTHDAY) YRS.:	IF UNDER 1 YR. MONTHS: 4	DAYS: 8	IF UNDER 24 HRS. HOURS:	MIN:
2c. DATE PRONOUNCED DEAD	MONTH: 2	DAY: 26	YEAR: 89	2d. HOUR: 9:22A M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C..	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED X ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.						
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): N/A	12b. KIND OF BUSINESS OR INDUSTRY: N/A						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Prince George	13c. CITY OR TOWN: Clinton	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS: 2104 Floral Rd					
14. FATHER'S NAME FIRST: Earl	MIDDLE: Allen	LAST: Sine	15. MOTHER'S MAIDEN NAME FIRST: Belinda	MIDDLE:	LAST: Shirley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: N/A	17. INFORMANT ADDRESS: Earl A. Sine/2104 Floral Rd/Clinton, Md.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sudden Infant Death Syndrome
Conditions, if ony, which gave rise to immediate couse (a) stating the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes
M.D. TITLE (SPECIFY): Acting Deputy Chief MEDICAL EXAMINER
DATE SIGNED: 2-27-89

V EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes,M.D. ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: March 1,1989	23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Landover, PrinceGeorge's Md	
24. FUNERAL DIRECTOR NAME / ADDRESS: J.B.Jenkins Funeral Home/7474 Landover Rd.		25a. DATE REC'D. BY REGISTRAR: MAR 06 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

07/84 25M BP422 DHMH - 17 (VR A15 ME (5))

02297 2

FEB 6 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05940
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Harper Eugene Shinn	2a. DATE OF DEATH MONTH DAY YEAR	02-03-89	2b. HOUR	03:35a M
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH MONTH DAY YEAR	06-30-13
6. AGE (IN YEARS LAST BIRTHDAY)	075 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	West Virginia	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George's MD.				
10. CITY OR TOWN OF DEATH	RIVERDALE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	LELAND MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Advertising
12b. KIND OF BUSINESS OR INDUSTRY	Newspaper				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	P.G.	HYATTSVILLE	YES ☒ NO ☐	5805 42nd Avenue #207 20781

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Harper P. Shinn	Metta Dean

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-------	213-09-8401	Dorothy E. Shinn	Same as #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) malnutrition

DUE TO, OR AS A CONSEQUENCE OF (b) aspiration pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) progressive esophageal cancer

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from Jan 28 19 88 to Feb 3 19 89, that (I) (we) last saw the deceased alive on Feb 2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STATE PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) D J KAUFFMAN

22e. ADDRESS Clinton, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 6, 1989	Ft. Lincoln Cemetery	Brentwood, Pr. Geo., Md.

24. FUNERAL DIRECTOR (NAME) / (ADDRESS)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781	FEB 9 '89	Julia Davidson-Kendall

022862 FEB 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

D-OR STATE REGISTRAR

89 05941
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Hazel | MIDDLE: A | LAST: Shorter

2a. DATE OF DEATH — MONTH: 02 | DAY: 03 | YEAR: 89

2b. HOUR: 6:40 AM

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH — MONTH: October | DAY: 8 | YEAR: 1908

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: Beltsville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Charwoman

12b. KIND OF BUSINESS OR INDUSTRY: US Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland | 13b. COUNTY: Prince Geo. | 13c. CITY OR TOWN: Laurel | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS / ZIP CODE: 8902 Merrill Lane Apt.203 20708

14. FATHER'S NAME — FIRST: Daniel | MIDDLE: | LAST: Turner

15. MOTHER'S MAIDEN NAME — FIRST: Beatrice | MIDDLE: | LAST: Jacobs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO | (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 579-40-2519

17. INFORMANT — ADDRESS: Lucille Fox 2434 2nd St., N.E. Wash., DC20002

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebravascular accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): HCVD & chronic CHF

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary heart disease.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. | MONTH | DAY | YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (this hospital) attended the deceased from 1 9 19 87 to 2 3 19 89 that (I) (we) last saw the deceased alive on 2 3 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H. A. Malavi DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): H. A. Malavi M.D.

22e. ADDRESS: 6005 Landover Rd. Cheverly, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 10, 1989

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION — CITY OR TOWN: Washington, D.C. | COUNTY | STATE: Washington, DC

24. FUNERAL DIRECTOR — NAME: McGuire Funeral Service | ADDRESS: 7400 Georgia AVe., NW

25. DATE RECEIVED BY REGISTRAR: FEB 13 1989

26. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for issuance of burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024998 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR — REG. NO. 89 005942

DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ]	MONTH	DAY	YEAR / 2b. HOUR
	Warren	EARL	Simon		2-11		19 89 / M
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR / 2d. HOUR
MALE	BLACK	September 2, 1946	42 YRS.			2-11	19 89 / 4:50 a.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia	U.S.A.		Prince George's County, MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Temple Hills	Rt. 95 at Auth Road	Clerical	Government				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	Prince Georges	Oxon Hill	YES [ ] NO [X]	1824 Jarvis Avenue 20745

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Rufus Simon	Minnie Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Army	228-64-5162	Corrine Simon	1824 Jarvis Avenue Oxon Hill, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple Injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	3:55 XX 2-11 19 89	driver of auto ran into the rear of a parked tractor-trailer

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	road	Rt. 95 at Auth Rd., Temple Hills, Prince George's Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [XX] Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Chief MEDICAL EXAMINER DATE SIGNED 2-11-89

EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	February 16, 1989	Lincoln Memorial	Suitland, Maryland

24a. FUNERAL DIRECTOR John T. Stewart, III ADDRESS 4001 Benning Road Washington, D.C.
Stewart Funeral Home

25a. DATE REC'D. BY REGISTRAR FEB 21 '89 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024909 MAR-8 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05943 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN MIDDLE: Francis LAST: SKINNER				2a. DATE OF DEATH MONTH DAY YEAR: 2.6.89	2b. HOUR: 1050 A M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: 02 25 32	6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE Georges Co MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SOUTHERN MARYLAND HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince Geo	Clinton	YES XX NO ☐	C/O 9106 Pineview Lane 20735

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Henry Skinner	Edith Gertrude Green	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES): no	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Thelma Smith 105 E. 35th St. Wilmington, Delaware 1980

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Cerebrovascular Accident

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Pneumonia - Sepsis - Bilateral Amputation - Renal Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/19/89 to 2/6/89 that (I) (we) last saw the deceased alive on 2/6/89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
[illegible]	[illegible] MD 20706

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/10/89	Christ UMC Cem	Baden, Prince Geo's MD

24. FUNERAL DIRECTOR NAME / ADDRESS: [illegible] Agusco Md 20608

25. DATE RECD. BY REGISTRAR: FEB 15 89 REGISTRAR'S SIGNATURE: Luba Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024467 MD 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05944
REG. NO.

FOR 1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT): FIRST Ira MIDDLE Marc LAST Smirlock

2a. DATE KNOWN OF DEATH / ESTIMATED: MONTH Feb DAY 24 YEAR 89 — 2b. HOUR 745 AM

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH April DAY 13 YEAR 38 — 6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 24 YEAR 89 — 2d. HOUR 745 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.

10. CITY OR TOWN OF DEATH: River Dale

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Mem. Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer

12b. KIND OF BUSINESS OR INDUSTRY: Litton System

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md — 13b. COUNTY: Mont. — 13c. CITY OR TOWN: Silver Spg — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: 14701 Silverstone Ave (20904)

14. FATHER'S NAME: FIRST Sidney MIDDLE LAST Smirlock

15. MOTHER'S MAIDEN NAME: FIRST Molly MIDDLE LAST Zamalin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — IF YES, GIVE WAR OR DATES: -------

16b. SOCIAL SECURITY NO.: 109-30-1009

17. INFORMANT: Loretta Smirlock; Wife — ADDRESS: 14701 Silverstone Dr Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Inf
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION: None — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: John S. Rogers, M.D. — TITLE (SPECIFY): Dep. MEDICAL EXAMINER — DATE SIGNED: Feb 24 89

EXAMINER'S NAME (TYPE OR PRINT): JOHN S. ROGERS, M.D. — ADDRESS: Seminary Road; Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2/26/89 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon Cemetery — 23d. LOCATION CITY OR TOWN COUNTY STATE: Adelphi; P.G.; Maryland

24. FUNERAL DIRECTOR NAME: DANZANSKY-GOLDBERG MEMORIAL CHAPELS — ADDRESS: 1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR: FEB 28 1989 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 - PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

50

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

022418 FEB 18 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 059455 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Beatrice — MIDDLE: — LAST: Smith

2a. DATE OF DEATH KNOWN ☑ ESTIMATED ☐ — MONTH: 2 — DAY: 1 — YEAR: 19 89 — 2b. HOUR: M

3. SEX: Female — 4. RACE: Black — 5. DATE OF BIRTH (MONTH DAY YEAR): 5-30-04 — 6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. — IF UNDER 1 YR. (MONTHS, DAYS) — IF UNDER 24 HRS. (HOURS, MIN)

2c. DATE PRONOUNCED DEAD — MONTH: 2 — DAY: 1 — YEAR: 19 89 — 2d. HOUR: 1640 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George's Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laundry Helper — 12b. KIND OF BUSINESS OR INDUSTRY: Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: PrinceGeorges — 13c. CITY OR TOWN: Landover — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 3131 75th Ave #204 — 2078

14. FATHER'S NAME — FIRST: Unknown — MIDDLE: — LAST:

15. MOTHER'S MAIDEN NAME — FIRST: Unknown — MIDDLE: — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 220-34-2514

17. INFORMANT — ADDRESS: Theresa Scrivner 15203 Peerless Ave Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic atherosclerotic Fibrosis and Varicosities

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-2-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2-4-89 — 23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial — 23d. LOCATION CITY OR TOWN: Landover COUNTY: Prince George's STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: JBJENKINSFunHome7474LandoverRdLandover,Md.

25a. DATE REC'D. BY REGISTRAR: FEB 08 1989 — 25b. REGISTRAR'S SIGNATURE:

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024914 MAR -8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05946
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARGARET	MIDDLE: ANN	LAST: SMITH	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 7, 1989	2b. HOUR: 3:04 am
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: June 19, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.	
10. CITY OR TOWN OF DEATH: Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Andrews A.F.B. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Private	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: District of Columbia	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 3030 30th Street, S.E.
14. FATHER'S NAME FIRST: William	MIDDLE	LAST: Stevenson	15. MOTHER'S MAIDEN NAME FIRST: Ella	MIDDLE	LAST: Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 105-18-7795	17. INFORMANT: Ethel S. Hale	ADDRESS: 707 Morrison Street Watertown, N.Y.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b): SEVERE PULMONARY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ~~I~~ (this hospital) attended the deceased from 01 DECEMBER 19 88, to 07 FEBRUARY 19 89, that (I) ~~(we)~~ last saw the deceased alive on 07 FEBRUARY 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Mark E. Mavity — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 07 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK E. MAVITY, CAPT, USAF, MC — 22e. ADDRESS: MALCOLM GROW USAF MEDCEN AAFB, MD 20331

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 12, 1989	23c. NAME OF CEMETERY OR CREMATORY: Northside Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Watertown, New York	
24. FUNERAL DIRECTOR NAME: John F. Stewart, III	ADDRESS: 4001 Benning Road, Washington, D.C.	25a. RECD. BY REGISTRAR: FEB 10 89	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	
Stewart Funeral Home				

BP_____

DHMH - 16 50M 1/81 (VRA 15-4)

024129 FEB 29 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05947
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME [TYPE OR PRINT] FIRST	MIDDLE	LAST
Mark	Todd	Smith

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 2 DAY 10 YEAR 89 — 2b. HOUR —

3. SEX: male — 4. RACE: white — 5. DATE OF BIRTH: MONTH Sept. DAY 1, YEAR 1965 — 6. AGE (IN YEARS LAST BIRTHDAY): 23 YRS. — IF UNDER 1 YR. MONTHS — DAYS — IF UNDER 24 HRS. HOURS — MIN. —

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 10 YEAR 89 — 2d. HOUR 10:09 p.m.

7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]: Washington DC — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince GEorge's County, MD.

10. CITY OR TOWN OF DEATH: Clinton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION [IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS]: Southern Maryland Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): carpenter — 12b. KIND OF BUSINESS OR INDUSTRY: construction

USUAL RESIDENCE [IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION]

13a. STATE: Maryland — 13b. COUNTY: Calvert — 13c. CITY OR TOWN: Dunkirk — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: Jester Ct. 20754

14. FATHER'S NAME FIRST	MIDDLE	LAST
Larry	Lorrain	Smith

15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Carol	Ann	Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO, OR UNKNOWN]: no — [IF YES, GIVE WAR OR DATES]: n/a — 16b. SOCIAL SECURITY NO.: 578-82-4270 — 17. INFORMANT ADDRESS: Larry L. Smith same as#13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

8150

IMMEDIATE CAUSE (a): Multiple Injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 8:44 P.M. 2-10 19 89 — 21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2]: driver ejected from auto after running off road, struck a tree and ran into ditch

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road — 21f. LOCATION STREET: east of Wallace Lane at Sulley Station Road, CITY OR TOWN: Prince George's Co. COUNTY: Md. STATE:

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John E. Smialek — TITLE (SPECIFY): M.D. Chief MEDICAL EXAMINER — DATE SIGNED: 2-11-89

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. — ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial — 23b. DATE: Feb 15, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Lakelawn Cemetery — 23d. LOCATION CITY OR TOWN: Reynoldsville COUNTY: Jefferson STATE: PA

24. FUNERAL DIRECTOR NAME: Rausch Funeral Home Owings MD — ADDRESS:

25a. DATE REC'D. BY REGISTRAR: FEB 13 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

024947 MAR -9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05948
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Orrin	Middle: Raymond	Last: Smith	2a. DATE OF DEATH Month: 2	Day: 26	Year: 89	2b. HOUR 7:10 PM
3. SEX: MALE	4. RACE: CAU.	5. DATE OF BIRTH Month: DEC. Day: 18 Year: 1922	6. AGE (IN YEARS LAST BIRTHDAY): ~~67~~ 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S MD.			
10. CITY OR TOWN OF DEATH: CHELTENHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 12302 VAN BRADY ROAD BOX 43	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): mailer	12b. KIND OF BUSINESS OR INDUSTRY: Post Newspaper			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	PG	CHELTENHAM	YES [ ] NO [X]	12302 VAN Brady Box 43 20623

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Lionel	Herbert	Smith	Letha	Jane	McCurdy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WWII	579 16 8285	Wife Lois Audrey	#13E

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory Failure	1 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinomatosis	3 yr
DUE TO, OR AS A CONSEQUENCE OF (c)	Carcinoma	3 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-2- 19 51 to 2-26 19 89, that (I) (we) last saw the deceased alive on 2-26 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Richard N Dobson	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	2-26-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Richard Dobson	Brandywine Waldorf Cl. Brandywine Md. 20613

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3-1-89	Trinity Memorial	Waldorf Charles Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	P.O. Box 156 Waldorf, Md. 20604	MAR 01 '89	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

Item 2a 2-23-89 Film 648

1 - FOR STATE REGISTRAR W.H.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05949
REG. NO.

1225935 FEB 13 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached together as the death transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Rexford	A.	Smith	4 Feb. 5,		1989 / 12:13a M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	Caucasian	Oct. 11, 1914	74 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	U.S.A.		Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Clinton	Southern Maryland Hospital	manager	Safeway Food Stores

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Pr.George's	UpperMarlboro	YES ☐ NO ☒	9809 Actium Dr., Upper Marlboro, MD 20772

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Cecil	A.	Smith	Lena	Katherine	Hall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	W.W. II	243-09-5390	wife M. Joan Smith	same as 13 a-e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b) metastatic colon cancer

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital attended the deceased from Jan 30 19 89 to Feb 3 19 89, that (I) (we) last saw the deceased alive on Jan 30 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DO HALDAK	8926 Woodyard Rd., Clinton MD 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 7,1989	MD Veterans Cemetery	Cheltenham, P.G. MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc. Old Alexander Ferry Rd., Clinton, MD 20735	FEB 09 1989	

BP

DHMH - 16 60M 7/84 (VRA 15, 6633)

024719 MAR 2 89

Items18a,22a per M.E. FilmG650 4/4/89 CG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 89 05950

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN xx ESTIMATED ☐ MONTH	DAY	YEAR 19	2b. HOUR M
Jeffrey	Allen	Norris Sommers	2-	20-	89	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19	2d. HOUR M
Male	White	Nov. 13, 1988		3	7			2-20- 89	5:30P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED xx WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Clinton	Southern Maryland Hospital	------	----

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MAryland	Prince Geo's	Upper Marlboro	YES xx NO ☐	4801-B Crane Highway/20772

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Jan	H.	Norris	Laura -- Sommers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-----		Laura Sommers- 4801-B Crane Highway, Upper Marlboro, Md. 20772

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sudden infant death syndrome

Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES xx NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy xx, Inspection ☐, Inquiry ☐ and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF M.D. Mario F. Golle Jr. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-21-89

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle,Jr.,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/23/89	Harmony Memorial Park	Landover (Pr.Geo's) Md.

24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Richard A. Coleman Funeral Home Upper Marlboro, Md. 20772	MAR 2 - 1989	Lucie Davidson-Randall

TO REGISTRAR OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP403 DHMH - 17 (VR A15 ME (5))

0249911 MAR -8 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005951

1. DECEASED NAME (TYPE OR PRINT)	FIRST Mary	MIDDLE Elizabeth	LAST Stewart	2a. DATE OF DEATH KNOWN ☐ ESTIMATED X	MONTH 02	DAY 13,	YEAR 1989	2b. HOUR 1130	A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 10 DAY 02 YEAR 1896	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH Feb	DAY 13.	YEAR 1989	2d. HOUR 1130	A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hyattsville Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Owner	12b. KIND OF BUSINESS OR INDUSTRY Self Employed

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN University Park	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS 6934 Pine Way 20782

14. FATHER'S NAME FIRST Andrew	MIDDLE	LAST McDonald	15. MOTHER'S MAIDEN NAME FIRST Mary / MIDDLE Ann / LAST Haight
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO. 536-30-8959	17. INFORMANT (Son) 6934 Pine Way James M. Stewart University Park, Md. 20782	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
887 IMMEDIATE CAUSE (a) Acute Myocardial Dis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None

19a. DATE OF OPERATION 8-22-88	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt. Hip	20. AUTOPSY? YES ☐ NO X
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED Feb 14 89

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 02/17/89	23c. NAME OF CEMETERY OR CREMATORY Bay View Cemetery	23d. LOCATION CITY OR TOWN Bellingham	COUNTY Whatcom STATE Washington
24. FUNERAL DIRECTOR (NAME AND ADDRESS) Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		25a. DATE REC'D. BY REGISTRAR FEB 17 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17
(VR A15 ME (5))

025392 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05952
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DEAN	MIDDLE: C.	LAST: STONEMAN	2a. DATE OF DEATH MONTH: FEB DAY: 28 YEAR: 1989	2b. HOUR: 5 00 AM
3. SEX: MALE	4. RACE: W Caucasian	5. DATE OF BIRTH MONTH: 6 DAY: 12 YEAR: 1930	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.	
10. CITY OR TOWN OF DEATH: LANAHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI DOCTORS of P.G.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Automobile	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Prince Georges	Bowie	YES ☒ NO ☐	8415 Zug Road 20715

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: Ernest MIDDLE: V. LAST: Stoneman	FIRST: Hattie MIDDLE: LAST: Frost

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes		579-42-0888	Faye S. Stoneman	Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Pulmonary Arrest.	
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma of lung.	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on 3/28, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	3/1/1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R. SOOD M.D.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3-4-89	George Washington	Adelpi Prince Georges Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, Maryland	MAR 14 1989	Gina Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024819 MAR-7 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

P- FOR STATE REGISTRAR

89 05953
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Donald MIDDLE LAST STRASNICK
2a. DATE OF DEATH: MONTH 2 DAY 28 YEAR 89
2b. HOUR 10:05 AM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: OCTOBER 20, 1912
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MASSACHUSETTS
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED XXX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE'S COUNTY MD.
10. CITY OR TOWN OF DEATH: RIVERDALE
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS): LELAND MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): CONTRACTOR
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: PRINCE GEORGE'S
13c. CITY OR TOWN: HYATTSVILLE
13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS: 5812 44th AVENUE 20781

14. FATHER'S NAME: FIRST MAX MIDDLE LAST STRASNICK
15. MOTHER'S MAIDEN NAME: FIRST DORA MIDDLE LAST ROTHENBERG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 012 18 5075
17. INFORMANT: DEBORAH FRAZER ADDRESS: 1052 LAKE CLAIRE DRIVE ANNAPOLIS, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cardiogenic Shock — 3 day
DUE TO, OR AS A CONSEQUENCE OF (c): Acute myocardial infarction — 3 day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Organic mental Syndrome due to old brain injury

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO XX
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug 88 to Feb 89 and that (I) (we) last saw the deceased alive on Feb 27 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Tung Pi Lee MD — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/28/1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT): TUNG PI LEE, MD
22e. ADDRESS: 7411 Riggs Rd Hyattsville MD 20783

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 3/2/1989
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCON CEMETERY
23d. LOCATION CITY OR TOWN: BRENTWOOD COUNTY: PR. GEO. STATE: MARYLAND
24. FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.
25a. DATE REC'D. BY REGISTRAR: MAR 3 - 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove clean papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal of remains.

IMPORTANT: If Item 21a marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

023761 FEB 26 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 05954

1. DECEASED NAME (TYPE OR PRINT) FIRST: GWEN	MIDDLE: M.	LAST: STROUP	2a. DATE OF DEATH MONTH: 02	DAY	YEAR: 1989	2b. HOUR: 1:15 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 4, 1887	6. AGE (IN YEARS LAST BIRTHDAY): 101 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.			
10. CITY OR TOWN OF DEATH: LAUREL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Beltsville	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher-Elementary School	12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Silver Spring	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 17217 Pinebrook Drive		20904
14. FATHER'S NAME FIRST: John	MIDDLE	LAST: Stroup	15. MOTHER'S MAIDEN NAME FIRST: Meria	MIDDLE	LAST: Lewis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 178 32 2608	17. INFORMANT: Robert Stroup	ADDRESS: Same as #13		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation
DUE TO, OR AS A CONSEQUENCE OF (b): Pleural effusion
DUE TO, OR AS A CONSEQUENCE OF (c): /
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Atelectasis / Cerebrovascular accident in past

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/10, 19 89, to 2/19, 19 89, that (I) (we) last saw the deceased alive on 2/17, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: John Margolis MD	DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/20/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): John Margolis	22e. ADDRESS: 14333 Laurel Bowie Rd #307 Laurel, Md 20708	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 22, 1989	23c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Southmont Brrgh., Pa.
24. FUNERAL DIRECTOR NAME AND ADDRESS: Ives-Pearson Funeral Homes, Arlington, Va. 22201		25a. DATE REC'D. BY REGISTRAR: FEB 22 1989	25b. REGISTRAR'S SIGNATURE: [illegible]

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025088 MAR 88

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05955
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Dorothy	E.	STUCKWISCH	February 21, 1989	*8:00 a.m.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	July 28, 1920	68 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Wash. D.C.	U.S.A.		Prince George's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	AMI Doctors' Hospital of PG County	House Wife	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	P.G.	College Park	YES ☒ NO ☐	4711 Berwyn House Rd. Apt.605 20740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joshua	P.	Taylor	Nellie	W.	Much

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	--------	579-12-4517	David P. Stuckwisch	15036 Laurel Oaks La. Laurel Md. 20707

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Lung

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (the hospital) attended the deceased from 1/1 19 89 to 2/20 19 89, that (I) (we) last saw the deceased alive on 2/19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE Barry Rosenberg DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Rosenberg M.D.

22e. ADDRESS 6501 Landover Rd., Cheverly, Md. 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/24/89	Ft. Lincoln Cemetery	Brentwood P.G. MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W.W.Chambers Co. Inc.	5801 Cleveland Ave. Riverdale Md.20737	FEB 23 '89	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024988 MAR-3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05956
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Esther	MIDDLE: Virginia	LAST: SULLIVAN	2a. DATE OF DEATH MONTH DAY YEAR: February 8, 1989		2b. HOUR: 7:30P M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 5 - 19 - 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctor's Hospital of P.G.C.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Co-Owner	12b. KIND OF BUSINESS OR INDUSTRY: Service Station		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Florida	13b. COUNTY: Pinellas	13c. CITY OR TOWN: St. Petersburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 878 40th Avenue, North	
14. FATHER'S NAME FIRST: Luther	MIDDLE: Robert	LAST: Dowden	15. MOTHER'S MAIDEN NAME FIRST: Ida	MIDDLE:	LAST: THarpe
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 214-03-0511	17. INFORMANT: Stuart E. Dowden	ADDRESS: 6310 Inwood Street Cheverly, Md. 20784	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c): SEVERE CONGESTIVE HEART FAILURE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): RENAL INSUFFICIENCY, ELECTROLYTE IMBALANCE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1 29 19 89, to 2 8 19 89, that (I) (we) last saw the deceased alive on 2 8 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: ARao — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Aroor Rao M.D.

22e. ADDRESS: 6130 Oxon Hill Rd., Oxon Hill, Md. 20745

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-11-89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood, Prince George's, Md	
24. FUNERAL DIRECTOR NAME / ADDRESS: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 05957 REG. NO.

122593 FEB 13 89

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JANIECE Matheson SUMNER			2a. DATE OF DEATH MONTH DAY YEAR	02 03 89
				2b. HOUR	10 50 PM
3. SEX	Female	4. RACE	Caucasian	5. DATE OF BIRTH MONTH DAY YEAR	March 5, 1902
6. AGE (IN YEARS LAST BIRTHDAY)	86 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Florida	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH	CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SOUTHERN MARYLAND HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	homemaker
12b. KIND OF BUSINESS OR INDUSTRY	home				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Florida	St.Lucie	Ft. Pierce	YES ☐ NO ☒	801 Ohio Avenue 34950

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Leolin Matheson	Bertha Sanderson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	n/a	262-43-4607	daughter: Earliene Rawe	5800 Sulla Ct. Clinton, MD 20735

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	massive ischemic stroke,bilateral	days.
DUE TO, OR AS A CONSEQUENCE OF (b)	severe cerbral arteriosclerosis	years.
DUE TO, OR AS A CONSEQUENCE OF (c)	atherosclerotic cornonary heart disease.	years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
degenerative joint disease, recurrent urinary tract infections.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec.19 1988 19 to Feb.3 1989, that (I) (we) last saw the deceased alive on Feb.3 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Peter [signature]	M.D.		Feb.4 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
PETER W.YIM M. D.	7900 OLD BRANCH AVE.SUITE 101 CLINTON,MARYLAND 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb9,1989	Riverview Mem. Pk.	Ft. Pierce, St. Lucie, FL

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd., CLinton, MD 20735	FEB 09 1989	Julia Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbanoppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005958

024993 MAT-0

1. DECEASED NAME (TYPE OR PRINT): FIRST Pietro MIDDLE P. LAST Sun

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 15 YEAR 1989 — 2b. HOUR

3. SEX: Male — 4. RACE: Chinese — 5. DATE OF BIRTH: MONTH 8 DAY 16 YEAR 28 — 6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 15 YEAR 1989 — 2d. HOUR 12 Noon

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): China — 7b. CITIZEN OF WHAT COUNTRY? China — 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's Co. MD.

10. CITY OR TOWN OF DEATH: Seat Pleasant — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 6608 Greig Street 101 — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Pot Washer — 12b. KIND OF BUSINESS OR INDUSTRY: Cosmos

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD. — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: Seat Pleasant — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 6608 Greig St. Apt.101 /20743

14. FATHER'S NAME: FIRST Leemin MIDDLE - LAST Sun

15. MOTHER'S MAIDEN NAME: FIRST UNK. MIDDLE - LAST Yer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): --------

16b. SOCIAL SECURITY NO.: 214-82-8117

17. INFORMANT ADDRESS: Bibiana Sun (Wife) Same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Renal Adenoma, Metastates — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Augusto P. Rodriguez, M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-15-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez M.D. — ADDRESS: 5009 Raeburn Ct. Camp Springs Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 2/17/89 — 23c. NAME OF CEMETERY OR CREMATORY: Chambers Crematory — 23d. LOCATION CITY OR TOWN: Riverdale COUNTY: P.G. STATE: Md.

24. FUNERAL DIRECTOR NAME: W.W.Chambers Co. Inc. — ADDRESS: 5801 Cleveland Ave. Riverdale MD. 20737 — 25a. DATE REC'D. BY REGISTRAR: FEB 17 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP____

DHMH - 17 (VR A15 ME (5))

022785 FEB 15 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05959
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ROBERT — MIDDLE: JAMES — LAST: SWANN

2a. DATE OF DEATH — MONTH DAY YEAR: FEBRUARY 7 1989 — 2b. HOUR: 745 AM

3. SEX: M

4. RACE: BLACK

5. DATE OF BIRTH — MONTH DAY YEAR: Dec 25 1904

6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CUMBERLAND, Va

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.

10. CITY OR TOWN OF DEATH: LARGO

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 9611 CEDAR HOLLOW LANE

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md

13b. COUNTY: PRINCE GEORGES

13c. CITY OR TOWN: LARGO

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 9611 Cedar Hollow LANE LARGO MD 20772

14. FATHER'S NAME — FIRST: ROBERT — MIDDLE: B — LAST: Swann

15. MOTHER'S MAIDEN NAME — FIRST: BETTIE — MIDDLE: F — LAST: ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 216 09 5338

17. INFORMANT: DORIS SWANN — ADDRESS: 9611 Cedar Hollow Lane LARGO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO pulmonary ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c): ISCHEMIC HEART DISEASE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBRAL VASCULAR ACCIDENT HYPERTENSION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 19 88 to FEB 7 19 89, that (I) (we) last saw the deceased alive on JANUARY 6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Helen Capone — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: FEBRUARY 7-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Helen CAPONE MD

22e. ADDRESS: 7501 SURRATTS Rd #105 Clinton MD 20735

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2-11-89

23c. NAME OF CEMETERY OR CREMATORY: ARBUTUS MEM. PARK

23d. LOCATION — CITY OR TOWN: ARBUTUS — COUNTY: BALTIMORE — STATE: MD

24. FUNERAL DIRECTOR — NAME: Chatmen-Harris Funeral Home — ADDRESS: Baltimore MD 1701-03 McCulloh St.

25a. DATE REC'D. BY REGISTRAR: FEB 10 1989

25b. REGISTRAR'S SIGNATURE: Sheba Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

024526 MAR 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05960
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SHERMAN	MIDDLE: L.	LAST: TAYLOR JR	2a. DATE OF DEATH MONTH: 02	DAY: 22	YEAR: 89	2b. HOUR: 4 54PM M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: DEC DAY: 10 YEAR: 1961	6. AGE (IN YEARS LAST BIRTHDAY): 27 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON DC	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS IF NOT HOSPITAL): PRINCE GEORGES HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): SECURITY GUARD	12b. KIND OF BUSINESS OR INDUSTRY: GUARDIAN SEC			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN: WASH DC	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 4446 E ST SE	99999	
14. FATHER'S NAME FIRST: SHERMAN	MIDDLE: L	LAST: TAYLOR SR	15. MOTHER'S MAIDEN NAME FIRST: CARRIE	MIDDLE	LAST: FLOYD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577 92 3984	17. INFORMANT: SHERMAN L TAYLOR SR	ADDRESS: 3725 HALLOWAY PL UPPER MARL. MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary [illegible]
DUE TO, OR AS A CONSEQUENCE OF (b): [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): AIDS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): [illegible]

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/14 19 88 to 2/22 19 89, that (I) (we) last saw decedent alive on 2/22 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/25/89	23c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEMORIAL	23d. LOCATION CITY: SUITLAND	COUNTY: MD STATE
24. FUNERAL DIRECTOR NAME: ALEXANDER S POPE	ADDRESS: 2617 PA AVE SE WASH DC	25a. DATE REC'D BY REGISTRAR: FEB 24 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

BP 99/99

DHMH - 16 (DM 7/84 (VRA 15, 4)

Items 8, 21d per M.E. FilmG651

023758 FEB 23 '89

FOR STATE REGISTRAR 5/16/89EG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 059611

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED BY THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Lee	MIDDLE Frank	LAST Thayer	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	MONTH 2	DAY 16	YEAR 19 89
2b. HOUR	M						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	White	June 18, 1956	33 YRS.				
2c. DATE PRONOUNCED DEAD	MONTH 2	DAY 16	YEAR 19 89	2d. HOUR 3:55 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Washington D. C.	7b. CITIZEN OF WHAT COUNTRY?	U. S. A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒		9. BALTIMORE CITY OR COUNTY OF DEATH	Prince Georges County MD.
10. CITY OR TOWN OF DEATH	Clinton	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Warehouseman	12b. KIND OF BUSINESS OR INDUSTRY	Produce

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Prince George's	Hyattsville	YES ☒ NO ☐	8139 15th Avenue	20783

14. FATHER'S NAME	FIRST Donald	MIDDLE	LAST Thayer	15. MOTHER'S MAIDEN NAME	FIRST Rita	MIDDLE	LAST Siegel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		212 68 0900	Rita Thayer,	8139 15th Avenue Hyattsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	12:08PM 2-16-89	Pedestrian struck by van

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☒ NOT WHILE AT WORK ☐	median strip	Branch Avenue, S. of Moore Lane, Brandywine, Prince Georges Co. MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Mario F. Golle Jr. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-17-89

VC EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle,Jr.,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	STATE	COUNTY
Cremation	2/18/1989	Metropolitan Crematory	Alexandria		Virginia

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME	232 CARROLL STREET, N. W., WASHINGTON, D. C.	FEB 22 1989	Lora Davidson-Randall

07/84 25M BP

DHMH - 17 (VR A15 ME (51))

022782 FEB 15 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005962 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Sharon; MIDDLE: Baldwin; LAST: Thigpen

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] MONTH 2 DAY 7 YEAR 19 89 — 2b. HOUR

3. SEX: FEMALE — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH 3 DAY 27 YEAR 51 — 6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 7 YEAR 19 89 — 2d. HOUR 11:20 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEST VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.

10. CITY OR TOWN OF DEATH: Upper Marlboro

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 13107 Burleigh Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): POSTAL EMPLOYEE

12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: PRINCE GEORGES — 13c. CITY OR TOWN: UPPER MARLBORO — 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET ADDRESS: 13107 BURLEIGH ST.

14. FATHER'S NAME — FIRST: REV. JAMES — MIDDLE: PERRY — LAST: BALDWIN

15. MOTHER'S MAIDEN NAME — FIRST: IRENE — MIDDLE: — LAST: VALENTINE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 578-70-6305

17. INFORMANT — NAME: BRENDA BALDWIN — ADDRESS: SISTER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Gunshot wound of left side of head and back of left chest

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. 2-7-89 MONTH DAY YEAR 19 89

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject shot

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 13107 Burleigh Street, Upper Marlboro, Prince Georges County, MD

22a. I certify that I took charge of the remains described above, held on Autopsy [XX] Inspection [ ] Inquiry [ ] and in my opinion death resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [XX] Undetermined manner [ ].

ACTUAL SIGNATURE: Margarita A. Korell M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 2-8-89

EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 13 FEB 89 — 23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM. PARK — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: LANDOVER, P.G. MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: FRAZIER'S FUNERAL HOME WASH, DC. 389 R FAUR

25a. DATE REC'D. BY REGISTRAR: FEB 10 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

Item1 PerM.E. FilmG651 5/31/89 CG

022456 FEB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

89 REG. NO. 005963

1. DECEASED NAME (TYPE OR PRINT): FIRST Weston (~~Western~~) MIDDLE W LAST Thigpen

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 2 DAY 7 YEAR 19 89 — 2b. HOUR

3. SEX: MALE — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH 6 DAY 12 YEAR 42 — 6. AGE (IN YEARS LAST BIRTHDAY): 46 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 7 YEAR 19 89 — 2d. HOUR 11:20 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NORTH CAROLINA — 7b. CITIZEN OF WHAT COUNTRY? US — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ XX — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.

10. CITY OR TOWN OF DEATH: Upper Marlboro — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN ONE, GIVE STREET ADDRESS): 13107 Burleigh Street — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DISABLED — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: P.G. — 13c. CITY OR TOWN: UPPER MARLBORO — 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 13107 BURLEIGH ST.

14. FATHER'S NAME: FIRST WILLIE MIDDLE LAST THIGPEN

15. MOTHER'S MAIDEN NAME: FIRST CARRIE MIDDLE LAST UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. — 17. INFORMANT: CHART — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Contact gunshot wound of right side of head
Conditions, if any, which gave rise to immediate couse (a) stating the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH 2 DAY 7 YEAR 19 89 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Self inflicted

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home — 21f. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE): 13107 Burleigh Street, Upper Marlboro, Prince Georges County, Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Naturol causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita A. Korell M.D. — TITLE (SPECIFY): Assistant MEDICAL EXAMINER — DATE SIGNED: 2-8-89

VC EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): REMOVAL — 23b. DATE: 2-10-89 — 23c. NAME OF CEMETERY OR CREMATORY: FAMILY CEMETERY — 23d. LOCATION CITY OR TOWN: TARBOR COUNTY: NORTH CAROLINA STATE

24. FUNERAL DIRECTOR NAME: E.L. PHILLIPS — ADDRESS: 1721 N. MONROE STREET — 25a. DATE REC'D. BY REGISTRAR: FEB 09 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE REASONS IN ITEMS 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 89 005964

02193 FEB 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 4 to the hospital with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LILLIAN	MIDDLE: D.	LAST: THOMAS	2a. DATE OF DEATH MONTH: 2 DAY: 4 YEAR: 89	2b. HOUR: 803 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 9 DAY: 1 YEAR: 02	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR MONTHS: DAYS: IF UNDER 24 HRS. HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's Co. MD.	
10. CITY OR TOWN OF DEATH: Greenbelt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greenbelt Health Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: own home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Odenton	13c. CITY OR TOWN: Crofton	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 1678 Carlisle Dr. 21114
14. FATHER'S NAME FIRST: George MIDDLE: LAST: Wainright			15. MOTHER'S MAIDEN NAME FIRST: Anna MIDDLE: LAST: Baxter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A (IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 579-14-6708		17. INFORMANT: Socrates Thomas ADDRESS: 18 Tanglewood Rd St. Simons, GA 31522	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic obstructive pulmonary disease — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I/this hospital) attended the deceased from JAN 1, 19 85, to FEB 4, 19 89, that (I) (We) last saw the deceased alive on JAN 26, 19 89, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) did/did not view the body after death.

22b. SIGNATURE: Nelson Goodman — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): NELSON G. GOODMAN MD — 22e. ADDRESS: 3231 SUPERIOR LANE BOWIE 20715

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2-5-1989	23c. NAME OF CEMETERY OR CREMATORY: Metropolitan	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Alexandria, VA
24. FUNERAL DIRECTOR NAME: Hines/Rinaldi	ADDRESS: Silver Spring, MD	25a. DATE REC'D BY REGISTRAR: FEB 6 1989	25b. REGISTRAR'S SIGNATURE:

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024427 MAR 89

1- FOR STATE REGISTRAR UNKNOWN 89-32

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 005965
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Antoine	MIDDLE:	LAST: Thompson	2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐	MONTH:	DAY:	YEAR: 19 89
2b. HOUR	M						
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH: MONTH Jan. DAY 7 YEAR 1970	6. AGE (IN YEARS LAST BIRTHDAY): 19 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 2-23- DAY YEAR 19 89	2d. HOUR: 2:35A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.				
10. CITY OR TOWN OF DEATH: Suitland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Suitland Pkwy./w. of Silver Hill	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Road Porter	12b. KIND OF BUSINESS OR INDUSTRY: APT Trenton Pk.				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: D.C.	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS: 3711 Horner Place, SE #4			
14. FATHER'S NAME: FIRST Ralph MIDDLE LAST Lurch			15. MOTHER'S MAIDEN NAME: FIRST Catherine MIDDLE LAST Barnes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-94-4141	17. INFORMANT: Tamiko Lurch (sis.)	ADDRESS: 3711 Horner Pl. SE #4				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐	
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2-23-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Occupant in auto/fixed object collision	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road	21f. LOCATION STREET: Suitland Parkway, CITY OR TOWN: w. of Silver Hill Road, COUNTY: Prince Georges Co. STATE: MD	

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita Korell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 2-23-89

VC EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	03-01-89	Washington National Cem.	Suitland	PG	Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Robert G. Mason	1661 Good Hope Road, SE	FEB 27 1989	Gina Davidson-Randall

07-84 25M BP

DHMH 417 (VR A15 ME (5))

022883 FEB 1989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 5 2 3 6 6

1. DECEASED NAME (TYPE OR PRINT): FIRST Charles MIDDLE LAST Tolbert, Jr.

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ MONTH 2 DAY 7 YEAR 1989 — 2b. HOUR M

3. SEX: Male

4. RACE: BLACK

5. DATE OF BIRTH: MONTH 2 DAY 28 YEAR 28

6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 7 YEAR 1989 — HOUR 12 30 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): LOUISIANA

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE MD.

10. CITY OR TOWN OF DEATH: OXON HILL

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 829 Neptune Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ENGINEER

12b. KIND OF BUSINESS OR INDUSTRY: US ARMY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: PRINCE GEORGE — 13c. CITY OR TOWN: OXON HILL — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 829 NEPTUNE AVE 20745

14. FATHER'S NAME: FIRST CHARLES MIDDLE LAST TOLBERT SR

15. MOTHER'S MAIDEN NAME: FIRST PEARL MIDDLE LAST WHITE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): ARMY

16b. SOCIAL SECURITY NO.: 437 34 3219

17. INFORMANT: RUBY TOLBERT-WIFE — ADDRESS: 829 NEPTUNE AVE OXON HILL MD 20745

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P. Rodriguez M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2-7-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto P. Rodriguez, M.D. — ADDRESS: 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 2/11/89 — 23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEMORIAL — 23d. LOCATION CITY OR TOWN: LANDOVER COUNTY: PRINCE GEORGE STATE: MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: ALEXANDER S POPE 2617 PA AVE SE WASH DC

25a. DATE REC'D. BY REGISTRAR: FEB 14 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Saunders Rondeau

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023952 FEB 23 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05967 A
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen MIDDLE: LAST: Toshok	2a. DATE OF DEATH MONTH DAY YEAR: February 13 1989	2b. HOUR: 12:30 PM	
3. SEX: Female	4. RACE: CAu.	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 18, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Charles	Waldorf	YES ☐ NO ☒	3664 Pine Cone Circle/20602

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
Jan FIRST MIDDLE Gidusko LAST	unavailable FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	-----	193-03-8552	Robert Ellis - same as # 13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Advanced Atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF (b): Advanced senile Dementia

DUE TO, OR AS A CONSEQUENCE OF (c): Fractured R Brain tumor

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1985, 19____, to 2/13, 19 89, that (I) (we) last saw the deceased alive on 2/12, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
George H. Wathen			2-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. George H. Wathen, M.D.	Pembrooke Square Suite 104 Waldorf, Maryland 20601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2-16-89	St. John's	Uniontown Fayette Penn.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Huntt Funeral Home	P.O. BOX 156 WALDORF, MARYLAND 20604	FEB 16 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Rodriguez P. G. Medicial Examiner Notified and released 2-13-89

BP 60

DHMH - 1650M 1/81 (VRA 15, 4)

024920 MAR-8 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 05968

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: WILBERT	MIDDLE	LAST: TOYE	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 2 1989	2b. HOUR: 9:57PM	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: February 28, 1920	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mississippi	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Camp Springs	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Andrews A.F.B. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Postal Worker		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: Prince Georges	13c. CITY OR TOWN: Ft. Washington	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 8504 Bella Vista Terrace 20744	
14. FATHER'S NAME FIRST: Joe	MIDDLE: Wing	LAST: Toye	15. MOTHER'S MAIDEN NAME FIRST: Ida	MIDDLE: Mae	LAST: Williams
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Air Force	16b. SOCIAL SECURITY NO.: 428-14-7266	17. INFORMANT: Lillie Toye	ADDRESS: 8504 Bella Vista Terrace Ft. Washington, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): HEMOPTYSIS

DUE TO, OR AS A CONSEQUENCE OF

(b): ADENOCARCINOMA OF RIGHT LUNG METASTATIC

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from February 2 19 89 to February 2 19 89, that I (we) last saw the deceased alive on February 2 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Michael S Epstein MD	DEGREE	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 2 Feb 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MICHAEL S. EPSTEIN, MAJ, USAF, MC	22e. ADDRESS: MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB MD 20331-5300		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: February 8, 1989	23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Landover, Maryland
24. FUNERAL DIRECTOR NAME: John T. Stewart	ADDRESS: 4001 Benning Road N.E. Stewart Funeral Home Washington, D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 10 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

023 30 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05969
REG. NO.

DUPLICATE TO VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The tax features that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Alice	G.	TRAVIS	February 10, 1989	3:40 a M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	Caucasian	Feb. 15, 1915	73 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
North Dakota	United States		Prince George's County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	AMI Doctors' Hospital of PG County	Homemaker	Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	P.G.	Bowie	YES ☒ NO ☐	12323 Whitehall Drive/20715

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Peter		Gorthy	Maybelle		Not Available

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		501-09-1288	John W. Travis	13419 Overbrook Lane Bowie, MD 20715

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pleural Effusions — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
887
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Ovarian Cancer.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Organic Brain Syndrome, Hip Fracture

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
9/18/88	Left Hip Fracture	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐	10:30 A.M. 9-16 1988	Her legs gave way while walking & she fell

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	Whitehall Drive Bowie Pr Geo. Md

22a. I certify that (I) (this hospital) attended the deceased from 1-Feb 9 1985 to 1-Feb 9 1989 that (I) (we) last saw the deceased alive on 1-Feb 9 1989, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Stuart Turkewitz	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stuart J. Turkewitz	7500 Greenway Ctr. Dr. Greenbelt, Md. 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/10/89	Metropolitan Crematory	Alexandria, Fairfax, Virginia

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	FEB 15 1989	[signature]

2/10/89 by Medical Examiner

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025099 MAR 99

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05970 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Edward	Fernand	Trumbule	February 26, 1989	5:10a M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	November 14, 1913	75 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Kansas	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hyattsville	5008 43rd Avenue	Sheet Metal Worker Engraving	Bureau of

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Pr. George's	Hyattsville	YES [X] NO [ ]	5008 43rd Avenue	20781

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Edgar	F.	Trumbule	Lidye		DeRidder

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	------	220-12-3612	Adele Trumbule	same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prostate cancer (metastatic) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [X]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from June 5, 1986 to Feb 26, 1989, that (I) (we) last saw the deceased alive on Feb 21, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Ralph W. Boccia MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Ralph Boccia	14808 Physicians Lane #212, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3-1-89	Fort Lincoln Cemetery	Brentwood Pr George's, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	RECEIVED/REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781	FEB 28 '89	Gisha Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 05971

023040 FEB 17 89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ALICE | MIDDLE: V. | LAST: TYSON

2a. DATE OF DEATH — MONTH DAY YEAR: 2-8-89

2b. HOUR: 955 A M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH — MONTH DAY YEAR: Sept. 8, 1913

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Riverdale

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): LELAND MEM. HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic

12b. KIND OF BUSINESS OR INDUSTRY: Cleaning

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. | 13b. COUNTY: P.G. | 13c. CITY OR TOWN: Chapel Oaks | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 5123 Duel Pl. 20743

14. FATHER'S NAME — FIRST: Landon | MIDDLE | LAST: Green

15. MOTHER'S MAIDEN NAME — FIRST: Ella | MIDDLE | LAST: Payne

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 579-09-3853

17. INFORMANT — ADDRESS: 8704 Post Oak Way | Vernon L. Tyson, Jr. - Landover, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARCINOMA OF TONGUE WITH METASTASIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): RENAL FALIURE

DUE TO, OR AS A CONSEQUENCE OF (c): ANEMIA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CORONARY ARTERY DISEASE. HYPER TENSION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 1/16, 19 89, to 2/8, 19 89, that (I) (~~we~~) last saw the deceased alive on 2/7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~ (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2.8.89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. PIOCH

22e. ADDRESS: 5632 Annapolis Rd Bladensburg Md 20710

23a. BURIAL, CREMATION, REMOVAL (~~other~~)

23b. DATE: 2/14/89

23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM. PARK

23d. LOCATION — CITY OR TOWN: LANDOVER | COUNTY: P.G. | STATE: MD.

24. FUNERAL DIRECTOR — NAME: H.S. WASHINGTON & SONS | ADDRESS: 4925 BURROUGHS AVE. N.E.

25a. DATE REC'D BY REGISTRAR: FEB 15 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If (autopsy) is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024596 MAR - 3 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05972
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certification has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LEE	MIDDLE	LAST: VAUGHN	2a. DATE OF DEATH MONTH DAY YEAR: 2/17/89	2b. HOUR: 4.10A M	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: April 15, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): S.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE MD.		
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Brickmason	12b. KIND OF BUSINESS OR INDUSTRY: Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: P.G.	13c. CITY OR TOWN: Capitol Hgts.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 4702 Nash St. 20743	
14. FATHER'S NAME FIRST: Marshall	MIDDLE	LAST: Vaughn	15. MOTHER'S MAIDEN NAME FIRST: Essie	MIDDLE: Brown	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 578-18-5794	17. INFORMANT: Elizabeth Vaughn-Cheverly, Md.	ADDRESS: 6113 State St.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	SEPTIC SHOCK	3 WEEKS
DUE TO, OR AS A CONSEQUENCE OF (b)	PNEUMONIA	3-4 WEEKS
DUE TO, OR AS A CONSEQUENCE OF (c)	ACUTE MYELOMONOBLASTIC LEUKEMIA	3 WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HYPERTENSION, DEGENERATIVE JOINT DISEASE, GOUT

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from JANUARY 25, 19 89, to FEBRUARY 17 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Napoleon L. Jacobs, Jr.	DEGREE: MD	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/20/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): NAPOLEON C. MARCELO	22e. ADDRESS: 8632 ANNAPOLIS RD #12 BLADENSBURG, MD 20710		

23a. BURIAL (DIRECT), CREMATION, REMOVAL	23b. DATE: 2/22/89	23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM. PARK	23d. LOCATION CITY OR TOWN: LANDOVER	COUNTY: P.G. STATE: MD.
24. FUNERAL DIRECTOR NAME: H. S. WASHINGTON & SONS ADDRESS: 4920 BLADENSBURG AVE. N.E.	25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall		

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Male Black April 15,1904 84

S.C. U.S.A. x

Brickmason Construction

Md. P.G. Capitol Hgts. x 4702 Nash St. 20743

Marshall Vaughn Essie Brown

No 578-18-5794 Elizabeth Vaughn-Cheverly, Md. 6113 State St.

25081 MAR-9 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05973
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	2b. HOUR
	Carl	Edward	Veitenthal, Jr.	February 21, 1989	6:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				MONTHS	DAYS	HOURS	MIN.
Male	White	Feb. 18, 1918	71 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, DC	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Prince George's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DID MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lanham	7521 Newberry Lane	Operation	C.I.A.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Florida	Lee	Cape Coral	YES ☒ NO ☐	1730 Sandy Circle 33904

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Carl	E.	Veitenthal, Sr.	Virgie		Pumphrey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS
Yes-Army	WWII & Korea 577-09-5031	Ann V. Boteler (Daughter)	7521 Newberry Lane Lanham, Maryland 20706

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cardiorespiratory arrest	1 minute
DUE TO, OR AS A CONSEQUENCE OF (b)	abdominal adenocarcinoma	8 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 7 88 to 2/21 89, that (I) (we) last saw the deceased alive on 2/17 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Bruce A. Silver	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Bruce A. Silver, M.D.	5454 Wisconsin Ave. #835 Chevy Chase, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/24/89	Arlington National Cem.	Arlington Virginia

24. FUNERAL DIRECTOR	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis GAsch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781	FEB 23 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

23297 FEB 21 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 005974

DECEASED NAME (TYPE OR PRINT): FIRST Martha MIDDLE E. LAST Walker

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 2 DAY 12 YEAR 1989 — 2b. HOUR M

3. SEX: Female — 4. RACE: Caucasian — 5. DATE OF BIRTH: MONTH 11 DAY 21 YEAR 1888 — 6. AGE (IN YEARS LAST BIRTHDAY): 100 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 12 YEAR 1989 — 2d. HOUR 3:56 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Texas — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.

10. CITY OR TOWN OF DEATH: Clinton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Homemaker — 12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Calvert — 13c. CITY OR TOWN: Huntingtown — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: 580 Carla Drive 20639

14. FATHER'S NAME: FIRST James MIDDLE LAST Jamison — 15. MOTHER'S MAIDEN NAME: FIRST Unknown MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): N/A — 16b. SOCIAL SECURITY NO.: 577-84-2923 — 17. INFORMANT: JaAnn Nairn — ADDRESS: Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interventricular conduction disorder — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Myeloproliferative Myeloid metaplasia

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 2/13/89

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. — ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 02/14/89 — 23c. NAME OF CEMETERY OR CREMATORY: Washington Natl. Cem. — 23d. LOCATION CITY OR TOWN COUNTY STATE: Suitland Prince George's Md.

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. — ADDRESS: 6632 Old ALexander Ferry Rd Clinton, Md 20735

25a. DATE REC'D BY REGISTRAR: FEB 16 1989 — 25b. REGISTRAR'S SIGNATURE: Tisha Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

022960 FEB 16 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 05975

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL (ITEM 18, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Queen	Esther	Walker	2/7		19 89	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	Black	Aug. 25, 1922	66 YRS.			2/7 19 89	2:30 P. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	United States		Prince George's County MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Landover	7430 Bell Haven	Commisary Clerk	Gov't.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
		Washington, D.C.		229 43rd Road, N.E. #304

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Sam	Keith	Lonnie	Martin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	N/A	225-14-5618	LaJuan Hemphill/7436 Bellhaven Ct. Landover, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial disease.	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
None		

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
		None

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 2/8/89

EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	12 Feb 89	Lawyers Chapel Church Cem.	Lynchburg,	Campbell County,	VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
JB Jenkins FH/7474 Landover Rd. Landover, MD	FEB 13 1989	Gina Davidson-Randall	

DZ/84 25M BP DHMH 417 (VR A15 ME (5))

022941 FEB 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 05976

1. DECEASED NAME (TYPE OR PRINT) FIRST: Shirley	MIDDLE	LAST: Walker	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH: 2 DAY: 9 YEAR: 19 89	2b. HOUR M			
3. SEX: Female	4. RACE: black	5. DATE OF BIRTH MONTH: 5 DAY: 23 YEAR: 37	6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH: 2 DAY: 9 YEAR: 19 89	2d. HOUR 7:12 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, DC	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.				
10. CITY OR TOWN OF DEATH: Cheverly	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince George's General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Printing Office	12b. KIND OF BUSINESS OR INDUSTRY: Govt.'				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: PG	13c. CITY OR TOWN: Capital Hghts.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 7505 Millwright Street 20743			
14. FATHER'S NAME FIRST: unknown MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST: Gladys MIDDLE LAST: Marshall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 579-50-6280	17. INFORMANT ADDRESS: William Walker, Jr./7505 Millwright St. Capital Hghts MD					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lung Cancer with metastases
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Augusto P Rodriguez M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-9-89

EXAMINER'S NAME (TYPE OR PRINT): Augusto R Rodriguez MD ADDRESS: 700 Lay burn Ct. Gaithersburg, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 15 Feb 89	23c. NAME OF CEMETERY OR CREMATORY: Arlington National	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Arlington, Virginia
24. FUNERAL DIRECTOR NAME / ADDRESS: JB Jenkins FH/7474 Landover Rd. Landover, MD	25a. DATE REC'D. BY REGISTRAR: FEB 13 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP

DHMH - 17
(VR A15 ME (5))

075398 mc 4-5-89

Items 18a, PT. 2, 21a, b, c, d, e, f, 22a per M.E. FOR STATE REGISTRAR Film G650 4/5/89 CG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 05977

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST					2a. DATE OF DEATH KNOWN XX ESTIMATED ☐	MONTH	DAY	YEAR 19	2b. HOUR
	William	Kenneth	Wallace						2-21-	89		M
3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	Black		07	19	1941	47 YRS.					2-21-89	9:20 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	United States		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Camp Springs	Andrews Air Force Base	Construction	Pvt

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
Maryland	Prince Georges	Forestville		6569 Hill-Mar Dr

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Buster		Wallace	Elnora	E.	Gray

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	N/A	Unknown	Rebecca Wallace/6519 Hill-Mar Dr Forestville, Md #201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute cocaine intoxication

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Arteriosclerotic cardiovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2/21 1989	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Unknown	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street	21f. LOCATION STREET 6600 Blk. Hillman Dr. CITY OR TOWN Forestville, P.G. COUNTY Co. STATE Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 2-22-89

VC EXAMINER'S NAME (TYPE OR PRINT) James Kaplan, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY STATE
Cremation	Feb 27, 1989	Cedar Hill	Suitland	PG Md

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
J.B. Jenkins FH/7474 Landover Rd/Landover, Md	MAR 06 '89	Julia Davidson-Randall	

07/84 25M BP421 DHMH - 17 (VR A15 ME (5))

024915 MAR - 8 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 005978

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
AGNES	Henry	WATERS	February 6, 1989	8:45 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
FEMALE	BLACK	June 13, 1908	80 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Prince Georges MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bowie	8720 Normal School Road	Retired	Teacher

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE
MD.	Prince Georges	Bowie		8720 Normal School Road 20715

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	T.	Henry	Florence	M.	Colbert

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	217-36-9491	Lawrence W. Henry	8630 Normal School Rd., Bowie, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple Decubitus	
DUE TO, OR AS A CONSEQUENCE OF (c)	Malnutrition	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from October 18, 19 88, to February 6, 19 89, that I (we) last saw the deceased alive on February 6, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Gary W. Jones, MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	February 7, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Gary W. Jones, M.D.	P.O. Box 385 Laurel, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	February 11, 1989	Ascension Catholic Church Cemetery	Bowie, Maryland

FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John T. Stewart, III Stewart Funeral Home	4001 Benning Road Washington, D.C.	FEB 10 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thus please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024770 MAR - 7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05979 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail cards, page 4 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alice	MIDDLE: Carawan	LAST: WEST	2a. DATE OF DEATH MONTH DAY YEAR: February 16, 1989	2b. HOUR: 6:00 am	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 10 - 12 - 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctors' Hospital of PG County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Payroll Clerk	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Pr. Georges	College Park	YES ☒ NO ☐	4615 Beechwood Road 20740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	William	Carawan	Sally	Ellen	Beacham

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT
No	------	239-03-0669	Cedric Beachem 3600 Sprucell Drive Silver Spring, Md. 20902

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

912

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): gastro-esophageal reflux Aspiration, Ischemic Heart Disease, Rheumatoid Arthritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from January 28, 19 89, to February 16, 19 89, that (I) (we) last saw the deceased alive on February 16, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
CHIN-CHUAN HSU,	M.D	☒ / ☐ / ☐	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CHIN-CHUAN HSU	6419 Baltimore Ave Riverdale, MD 20737

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-18-89	Ft. Lincoln Cemetery	Brentwood, Pr. George's, Md

24. FUNERAL DIRECTOR NAME / ADDRESS: Harry C. Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Md. 20781

25a. DATE REC'D. BY REGISTRAR: FEB 21 '89

25b. REGISTRAR'S SIGNATURE: Gracia Davidson-Mendell

(10)

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023011 FEB 16 89 FOR STATE REGISTRAR

Items 18a, 22a per M.E. Film G650 4/28/89 Cg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 89 005980

1. DECEASED NAME (TYPE OR PRINT): FIRST Vornell MIDDLE LAST West

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH 2 DAY 10 YEAR 1989 — 2b. HOUR M

3. SEX: Male — 4. RACE: Black — 5. DATE OF BIRTH: MONTH 4 DAY 19 YEAR 19[illegible] — 6. AGE (IN YEARS LAST BIRTHDAY): 18 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 11 YEAR 1989 — 2d. HOUR 8:07 a.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASH. D.C. — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County, MD.

10. CITY OR TOWN OF DEATH: Bladensburg — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 5207 Newton Street, Apt. T4 — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland — 13b. COUNTY: Prince George's — 13c. CITY OR TOWN: Bladens. — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 5207 Newton Street 20710 APT T4

14. FATHER'S NAME: FIRST Unknown MIDDLE LAST — 15. MOTHER'S MAIDEN NAME: FIRST Linda MIDDLE LAST West

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: N/A — 17. INFORMANT: Linda W. C. Coates — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cardiac arrythmia
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. — TITLE (SPECIFY): Chief MEDICAL EXAMINER — DATE SIGNED 2-11-89

EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D. — ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2-18-89 — 23c. NAME OF CEMETERY OR CREMATORY: Lincoln — 23d. LOCATION CITY OR TOWN: Suitland COUNTY STATE: Md

24. FUNERAL DIRECTOR NAME: W. H. Bacon — ADDRESS: 3442-14th NW

25. DATE REC'D. BY REGISTRAR: FEB 14 1989 — 26. REGISTRAR'S SIGNATURE: Lisha Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PERSON IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M BP 341 DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 89 059 8

023452 FEB 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	John F. Westborg	2a. DATE OF DEATH — MONTH / DAY / YEAR	02 14 89	2b. HOUR 3:25 PM
3. SEX	Male	4. RACE	Cauc.	5. DATE OF BIRTH — MONTH / DAY / YEAR: 07 19 24
6. AGE (IN YEARS LAST BIRTHDAY)	64 YRS.	IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS — HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	New York	7b. CITIZEN OF WHAT COUNTRY?	United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince Georges MD.			
10. CITY OR TOWN OF DEATH	Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Greater Laurel-Beltsville Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Soldier
12b. KIND OF BUSINESS OR INDUSTRY	U.S. Army			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P.G.	Bowie	YES [XX] NO [ ]	12316 Firtree Lane/20715

14. FATHER'S NAME — FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST		
Robert Westborg	Hana	Nora	Martin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
Yes	1942-1973	109-16-4270	Alice B. Westborg, Same as # 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF (c) Renal Faliure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hepatic encephalopathy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-20-89 to 2-14-89, that (I) (we) last saw the deceased alive on 2-14-89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. SINGH

22e. ADDRESS 5632 Annapolis Rd #9 Bladensburg Md 20710

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	2/17/89	MD Veteran's Cemetery	Cheltenham, P.G., Maryland

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR
Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715	FEB 21 1989	

10 BP

DHMH - 16 60M 7/84 (VRA 15, 4)

025008 MAR - 3 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05982 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: John	MIDDLE: Nelson	LAST: Whitehead	2a. DATE OF DEATH MONTH DAY YEAR: February 25, 1989
2b. HOUR: M			
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 30, 1929	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County, MD.
10. CITY OR TOWN OF DEATH: Bowie	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2407 Belair Dr.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Public Schools

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: P.G.	13c. CITY OR TOWN: Bowie	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 2407 Belair Drive/20715

14. FATHER'S NAME FIRST: Nelson	MIDDLE: Biggs	LAST: Whitehead	15. MOTHER'S MAIDEN NAME FIRST: Gertrude MIDDLE: LAST: Love

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Korea	16b. SOCIAL SECURITY NO.: 284-24-9248	17. INFORMANT ADDRESS: Elinor S. Whitehead, Same as # 13.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Lung Cancer — 6 months
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 15 Nov 88 to 25 Feb 89, that (I) (we) last saw the deceased alive on 15 Feb 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Thomas A. Bowman MD — 22e. ADDRESS: 2525 Greenway Cir Dr. Greensboro MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Mar. 2, 1989	23c. NAME OF CEMETERY OR CREMATORY: Glen Rest Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Reynoldsburg, Franklin, Ohio	24230

24. FUNERAL DIRECTOR NAME / ADDRESS: Beall-Evans Funeral HOme, P.A. 16000 Annapolis Rd. Bowie, MD 20715

25a. DATE REC'D. BY REGISTRAR: MAR 3 - 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

025009 MAR - 9 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

39 05983
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Atlee Pomerene WHITELEATHER	2a. DATE OF DEATH MONTH DAY YEAR	February 21, 1989	2b. HOUR	M
3. SEX	Male	4. RACE	Caucasian	5. DATE OF BIRTH MONTH DAY YEAR	May 17 1910
6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Ohio	7b. CITIZEN OF WHAT COUNTRY?	United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Prince George's County MD.				
10. CITY OR TOWN OF DEATH	Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	AMT Doctors' Hospital of PG County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Truck Driver
12b. KIND OF BUSINESS OR INDUSTRY	Washington Suburban Sanitation Comm.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Prince George	GlennDale	YES [ ] NO [ ]	11501 Annapolis Rd.20769

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Walter Scott Whiteleather	Birdie Summer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		213-05-0677	Atlee P. Whiteleather,Jr. 11404 Daise Lane Glen. Dale, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Atherosclerotic Heart Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	19	

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from Oct 88, 19____, to Feb 21th 19 89, that (I) (we) last saw the deceased alive on Feb 21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-2-25-89	Moultrie Cemetery	Moultrie, Ohio

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Beall-Evans Funeral Home, P.A 16000 Annapolis Rd. Bowie, MD 20715	MAR 3 - 1989	Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024060 FEB 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 059834 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
PEARL	A.	WIBER	02	22	89 / 1:30A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	Black	Jan	27	1923	66 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Tennessee	United States		PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	Chef	Private

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	PG	Mitchellville	YES XX NO ☐	3614 Ripplingbrook Court 20716

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ernest		Johnson	Ethel		Palton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	N/A	579-09-3715	Lavida Sistrunk/3614 Ripplingbrook Ct.	Mitchellville, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ARRHYTHMIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CARDIOMYOPATHY

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN / YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from Aug 88 to 2/22 19 89, that (to the best of my knowledge) death occurred at the time and date stated above, and that I (my) last saw the deceased alive on 2/21 19 89. I did not view the body after death.

22b. SIGNATURE [signature] DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Derek M Schussler MD

22e. ADDRESS 7500 Greenway Ctr Dr Greenbelt MD 20770

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	25 Feb 89	Harmony Memorial Park	Landover	PG	Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
JB Jenkins FH/7474 Landover Rd. Landover, MD	FEB 23 1989	Julia Davidson-Randall

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

023934 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05985
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and part Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANNA MIDDLE: LAST: WILKES			2a. DATE OF DEATH MONTH DAY YEAR: 2-9-89	2b. HOUR: 7.30 PM
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: APRIL 11 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYIVANIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SO. MARYLAND HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: NONE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: M.D.	13b. COUNTY: P.G.	13c. CITY OR TOWN: OXON HILL	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 2164 ALICE AVE #202 20745
14. FATHER'S NAME FIRST: EDWARD MIDDLE: LAST: WRIGHT		15. MOTHER'S MAIDEN NAME FIRST: DRUCELA MIDDLE: LAST: WRIGHT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 579-26-0982	17. INFORMANT ADDRESS: JOSEPHINE FULLER 2164 ALICE AVE #202 OXON HILL MARYLAND		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Cardiac Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): old CVA - Renal Failure - COPD - Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/7 19 89 to 2/9 19 89, that (I) (we) last saw the deceased alive on 2/9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: K. Mostaan MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): K. EZA MOSTAAN — 22e. ADDRESS: 9235 25th Ave Md 20745

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-15-89	23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY	23d. LOCATION CITY OR TOWN: BLADENS BRUG COUNTY: P.G. STATE: M.D.	
24. FUNERAL DIRECTOR NAME: ROLLINS FUNERAL HOME, INC. ADDRESS: 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019		25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

PER: MOTHER ITEM #1 FILM#g652

024782 MAR 7 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR 6/8/89 J.A.

REG. NO. 89 052986

1. DECEASED NAME (TYPE OR PRINT): KELVIN ~~Kevin~~ P. Wilkins
2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ — MONTH 2 DAY 23 YEAR 89
2b. HOUR: M
3. SEX: MALE
4. RACE: BLACK
5. DATE OF BIRTH: MONTH 01 DAY 01 YEAR 64
6. AGE (IN YEARS LAST BIRTHDAY): 25 YRS.
IF UNDER 1 YR. MONTHS / DAYS
IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 23 YEAR 89
2d. HOUR: 1:30A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.
10. CITY OR TOWN OF DEATH: Mt. Rainier
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sidewalk front of 33rd St.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chief Cook
12b. KIND OF BUSINESS OR INDUSTRY: Restuarant

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: PG
13c. CITY OR TOWN: Mt.Ranier
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 4014-35th. Street 20712

14. FATHER'S NAME: Joseph E. Wilkins
15. MOTHER'S MAIDEN NAME: Alice Goode
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 214-92-3253
17. INFORMANT ADDRESS: Alice L. Wilkins/mother/same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple shotgun wounds to neck and chest
Conditians, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. 1:24AM MONTH 2 DAY 23 YEAR 89
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject shot
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): street
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: front/33rd Street, Mt. Ranier, Prince Georges County, Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐.

ACTUAL SIGNATURE: Margarita A. Korell M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER
DATE SIGNED: 2-23-89
EXAMINER'S NAME (TYPE OR PRINT): Margarita A. Korell, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-28-89
23c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood/PG/Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Marshall's Funeral Home-4217-9th.St.NW Washington, DC
25a. DATE REC'D. BY REGISTRAR: MAR 8 - 1989
25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN[illegible] ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP____ DHMH - 17 (VR A15 ME (5))

024996 MAR 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 059837

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
RICHARD	J.	WILLIAMS	02	06	89	4 50PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
MALE	BLACK	01	03	24	65 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Gulfport, Mississippi	U.S.A.		PRINCE GEORGES COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGES HOSPITAL CENTER	Retired	U.S. Government

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 20743

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
MD.	Prince Georges	Capitol Heights		409 Dateleaf Avenue

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Richard	Jonas	Williams	Mary		Butler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Marines	428-16-1105	Maria A. Williams	3301 New Hampshire Ave., N.W. Wash. D

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BRAIN STEM INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL EDEMA

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/6/89 to 2/6/89, that (I) (we) last saw the deceased alive on 2/6/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Ramesh Patel DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED 2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMESH PATEL (RAMESH PATEL)

22e. ADDRESS 3001 HOSPITAL DRIVE CHEVERLY MARYLAND 20785

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	February 13, 1989	Cheltenham Veterans Cem.	Cheltenham,	Maryland	

24a. FUNERAL DIRECTOR (NAME) Norman L. Stewart, III ADDRESS 4001 Benning Rd., Washington, D.C.

24b. FUNERAL HOME Stewart Funeral Home

25a. DATE REC'D BY REGISTRAR FEB 21 '89

25b. REGISTRAR'S SIGNATURE Gloria Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(10)

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

021989 FEB -8 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 059383
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If the cause listed on line 18 or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: THOMAS MIDDLE: G. LAST: WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR: 02/01/89	2b. HOUR: 4.40P M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: July 25, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): South Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH: CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): PRINCE GEORGES HOSPITAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Claims Examiner	12b. KIND OF BUSINESS OR INDUSTRY: Treas Dept
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: PG	13c. CITY OR TOWN: Landover	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 2007 Virginia Ave 20785
14. FATHER'S NAME FIRST MIDDLE LAST: Thomas M. Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Ella Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 577-22-0694		17. INFORMANT ADDRESS: Marjorie A. Kinard/1303 Mapleview Pl Wash., DC	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SE
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): pancreatic cancer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/6/89 to 2/1/89 19___, that (I) (we) last saw the deceased alive on 2/1/89 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-2-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph Vaughn MD

22e. ADDRESS: 6492 Landover Rd. Cheverly, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-8-89	23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem Park	23d. LOCATION CITY OR TOWN: Landover COUNTY: Md STATE	
24. FUNERAL DIRECTOR NAME: Marshall's Funeral Home ADDRESS: 4217 9th St NW: Washington, D.C.			25a. DATE REC'D. BY REGISTRAR: FEB 07 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

023290 FEB 2 1989

FOR STATE REGISTRAR Charlotte Anne Wilsey

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05983
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If items 24 marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CHARLOTTE	MIDDLE: ANNE	LAST: Wilsey	2a. DATE OF DEATH MONTH DAY YEAR: 2-5-89	2b. HOUR: 9:22 p.m.	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 28, 1938	6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARITAL STATUS: MARRIED XX; NEVER MARRIED ☐; WIDOWED ☐; DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges MD.		
10. CITY OR TOWN OF DEATH: Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ref. Specialist	12b. KIND OF BUSINESS OR INDUSTRY: Library		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Charles	Hughesville	YES ☐ NO XX	303 Beverly Drive/ 20637

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
James / / MacLain	Beatrice / / Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no --------	066-32-4896	Neal Wilsey - same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant pleural effusions — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse mixed histiocytic-lymphocytic lymphoma, Stage IVB — 2 yrs 5 mos
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO XX	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from September 19 86 to February 19 89, that (I) (we) last saw the deceased alive on 2-5 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	22c. DATE SIGNED
Kai-Yin Young, MD — ATTENDING PHYSICIAN XX; MEDICAL DIRECTOR ☐; STAFF PHYSICIAN ☐	2-6-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Kai-Yin Young, MD.	8526 Woodyard Rd #201 Clinton, MD 20735

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	2-8-89	Trinity Memorial	Waldorf, Charles, Md STATE

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hunter Funeral Home	P. O. Box 156 Waldorf, Md. 20604-0156	FEB 07 '89	Julia Davidson-Randall

BP 10

DHMH - 16 50M 4/83
(VRA 15, 4)

024990 MAR - 9 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 005990

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELEANOR	MIDDLE: Ruth Peyton	LAST: WILSON	2a. DATE OF DEATH MONTH: FEB	DAY: 12	YEAR: 1989	2b. HOUR: 9:37 A M
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: July	DAY: 7	YEAR: 1939	6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.			
10. CITY OR TOWN OF DEATH: Brentwood MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3723 Perry Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Prince Georges	Brentwood	YES ☑ NO ☐	3723 Perry Street 20722

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Robert	Simmie	Peyton	Ruth	J.	Henderson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		232-66-4933	(Husband) Harry E. Wilson, Sr.	3723 Perry Street Brentwood, Md. 20722

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hepatic Failure	2 months
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic Carcinoma of the Cervix	2½ years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from 9-15 19 87, to 2-11 19 89, that I (we) last saw the deceased alive on 2-13 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Jeffrey M. Crane	MD	☐ ☑ ☐	FEB. 13, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JEFFREY M. CRANE M.D.	14808 Physicians Lane # 212 Rockville, MD 20850

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/17/89	Underwood Cemetery	Charleston Kanawha W.Va.

24. FUNERAL DIRECTOR ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781	FEB 17 '89	Julia Davidson Randolph

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

022275 FEB 10 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05991
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: JEWEL Middle: O. Last: WILSON			2a. DATE OF DEATH Month Day Year: 2-3-89	2b. HOUR: 8:45 P M
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month Day Year: 1 21 18	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: P. G. MD.	
10. CITY OR TOWN OF DEATH: Maryland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret. Res. Mgr.	12b. KIND OF BUSINESS OR INDUSTRY: Ft. Lincoln
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: D. C.	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: Senior Citizens Bldg 2855 Bladensburg Rd. N.E. 512
14. FATHER'S NAME First Middle Last: Frederick Oscar			15. MOTHER'S MAIDEN NAME First Middle Last: Katie Plummer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 577-60--1974	17. INFORMANT ADDRESS: Ms. Sharon Massey/daughter/3015 Logan St. Forestville, Md. 20747	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): CONGESTIVE CARDIO MYO PATHY
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): CARCINOMA OF LUNG & CHRONIC OBSTRUCTIVE LUNG DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-29, 19 89, to 2-3-, 19 89, that (I) (we) last saw the deceased alive on 2-3-89, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/3/89
22d. PHYSICIAN'S ~~S~~NAME (TYPE OR PRINT): KJUSEPH MATHEW	22e. ADDRESS: 6510 Kenilworth Ave Riverdale, md 20737		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-8-89	23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS: John T. Rhines Co., 3015 12th St. N.E., D.C.	25a. DATE REC'D. BY REGISTRAR: FEB 08 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP

DHMH-16 50M 1/81 (VRA 15, 4)

Item 8a, 22a per M.E. Film G658

0253 11 MAR 1 '89

FOR STATE REGISTRAR 4/24/89 CG

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 05992
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN ☐ OF DEATH ESTIMATED XX MONTH	DAY	YEAR	2b. HOUR
JOSEPH	FRANK	WILSON III	2-	4-	19 89	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	Black	Aug.18,1969	19 YRS.					2-4- 19 89	1:30A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Wash.D.C.	U.S.A.		Prince Georges County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Temple Hills	4000 24th Avenue	Student	none

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
Maryland	P.G.	Temple Hills		4000 24th Ave. 20748

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	F.	Wilson Jr.	Diane	B.	Butler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Diane Harris 4000 24th Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sickle cell disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above; held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural Causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-6-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb.10,89	Harmony Mem.Park	Landover		Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HUNT FUNERAL HOME	2801 7TH ST. N.E. D.C.	MAR 07 1989	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP467

DHMH - 17 (VR A15 ME (5))

024905 MA 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 89 005993

1. DECEASED NAME (TYPE OR PRINT): FIRST Roy MIDDLE ROGER LAST WINN

2a. DATE OF DEATH: MONTH 2/11/89 DAY YEAR 2b. HOUR 5 PM

3. SEX: MALE

4. RACE: CAU.

5. DATE OF BIRTH: MONTH FEB. DAY 18 YEAR 1913

6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George County MD.

10. CITY OR TOWN OF DEATH: Clinton m.d.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Southern Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Freight Handler

12b. KIND OF BUSINESS OR INDUSTRY: Railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: CHARLES

13c. CITY OR TOWN: WALDORF

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: Box 24B Idlewood Trailer Park 20601

14. FATHER'S NAME: FIRST GRAHAM MIDDLE LAST WINN

15. MOTHER'S MAIDEN NAME: FIRST SUSAN MIDDLE SHEPHERD LAST BELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): -------

16b. SOCIAL SECURITY NO.: 579 12 7562

17. INFORMANT / Wife ADDRESS: URSULA MARY WINN #13E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rupture of abdominal aneurysm
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c): Cardiogenic Shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 2/11/89

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Laparotomy for repair of abdominal aneurysm

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 19 78 to Feb. 19 89, that (I) (we) last saw the deceased alive on 2/10/89 19 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mercedes Moasser DEGREE MD
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 2/13/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MOASSER-MD.

22e. ADDRESS: Stand by Medical Clinic MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2-15-89

23c. NAME OF CEMETERY OR CREMATORY: TRINITY MEMORIAL

23d. LOCATION (CITY OR TOWN) WALDORF (COUNTY) CHARLES (STATE) MD.

24. FUNERAL DIRECTOR (NAME) HUNTT FUNERAL HOME, INC. (ADDRESS) P.O. BOX 156 WALDORF, MD. 20604

25a. DATE REC'D. BY REGISTRAR: FEB 15 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 — requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes," (18) must show any injury, or other traumatic event, the cause of which (whether accidental, suicidal or homicidal) is to be reported to the medical examiner.

Released 2-12-89 Medical Examiner Notified Dr. Rodriguez P.G.

BP

6

DHMH - 16 50M 4/83 (VRA 15, 4)

Hutt F. H.

023378 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05994
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Carol	MIDDLE: Martha	LAST: WISE	2a. DATE OF DEATH MONTH DAY YEAR: January 30, 1989	2b. HOUR: 8:00 a	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 6, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's MD.		
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctors' Hospital of PG County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesclerk	12b. KIND OF BUSINESS OR INDUSTRY: Dept. Store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Pr. Geos.	13c. CITY OR TOWN: Hyattsville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 5805-42nd Ave./20781	
14. FATHER'S NAME FIRST: John	MIDDLE: Arthur	LAST: Wells	15. MOTHER'S MAIDEN NAME FIRST: Ida	MIDDLE: M.	LAST: Duckett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ---	16b. SOCIAL SECURITY NO.: 577-22-8323	17. INFORMANT: Marjorie W. Dickie	ADDRESS: 2052 Belmont Rd., NW, Washington, D.C.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Edema

DUE TO, OR AS A CONSEQUENCE OF (c): Pneumonia
Carcinoma Esophagus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Exhaustion secondary to Carcinoma Esophagus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-20-89, 19 89, to 1-30-89, 19 89, that (I) (we) last saw the deceased alive on 1-29-89, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: T. M. Din	DEGREE: M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/30/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): S. M. DIN, M.D.	22e. ADDRESS: 6510 Kenilworth Ave, Riverdale, M.D. 20737		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/2/89	23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Brentwood, MD	
24. FUNERAL DIRECTOR NAME: Joseph Gawler's Sons, Inc. ADDRESS: 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE REC'D BY REGISTRAR: FEB 02 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 16

DHMH - 1650M 1/81 (VRA 15, 4)

024466 MAR -2 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05995
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: Eleanor Middle: Marie Last: WISE		2a. DATE OF DEATH Month Day Year: February 24, 1989	2b. HOUR: 11:25 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH Month Day Year: DEC 19 1919	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON DC	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George's County MD.
10. CITY OR TOWN OF DEATH: Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AMI Doctors' Hospital of PG County	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SALES CLERIC	12b. KIND OF BUSINESS OR INDUSTRY: WOOLCO
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: PRINCE GEO	13c. CITY OR TOWN: LANHAM	13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 5305 BARKER PLACE 20706			
14. FATHER'S NAME First: HARVEY Middle: Last: MORELAND		15. MOTHER'S MAIDEN NAME First: JESSIE Middle: Last: WATKINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-18-9234	17. INFORMANT: GARY M. WISE	ADDRESS: 5305 BARKER PL. LANHAM

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): diffuse arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes Mellitus.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal failure, Respiratory failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE EARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 89 to 2/24 19 89, that (I) (we) last saw the deceased alive on 2/24 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/24/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): T. CHANCHIEN. 22e. ADDRESS: 8834 Cunningham Drive B.H.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 27 1989	23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery	23d. LOCATION CITY OR TOWN: Adelphi COUNTY: PG STATE: MD 20783	
24. FUNERAL DIRECTOR NAME: Tilkom Funeral Home & Chapel ADDRESS: 254 Carroll Ave DC	25a. DATE RECD. BY REGISTRAR: FEB 28 1989	25b. REGISTRAR'S SIGNATURE: Gina Washington-Randall		

024789 MAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 059956

1. DECEASED NAME (TYPE OR PRINT) FIRST: KENNETH	MIDDLE:	LAST: WISOR, Sr -	2a. DATE OF DEATH MONTH: 02	DAY: 14	YEAR: 89
2b. HOUR: 9:39 AM					
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 03 DAY: 27 YEAR: 1919	6. AGE (IN YEARS LAST BIRTHDAY): 69Y YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS. HOURS: MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: PRINCE GEORGE CO MD.		
10. CITY OR TOWN OF DEATH: CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SO. MARYLAND HOSPITAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Plumber	12b. KIND OF BUSINESS OR INDUSTRY: Plumbing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Pr George	13c. CITY OR TOWN: Temple Hills	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 5630 Fisher Road 20748	
14. FATHER'S NAME FIRST: Wilber T MIDDLE: LAST: Wisor	15. MOTHER'S MAIDEN NAME FIRST: Emma MIDDLE: LAST: Hamilton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 200 05 4278	17. INFORMANT: Kenneth Wisor, Jr	ADDRESS: Germantown Md 20874 19233 Gunnerfield La		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — 9 years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Peripheral Vascular Disease · Cerebrovascular Insufficiency

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 79 to Feb 14 19 89, that (I) (we) last saw the deceased alive on Dec 23 19 88, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. Sanford Young — DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Sanford Young — 22e. ADDRESS: 11701 Livingston Road Ft Wash., Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Feb 16 1989	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION CITY OR TOWN: Suitland	COUNTY: PGC STATE: Maryland
24. FUNERAL DIRECTOR NAME: Robert E Wilhelm FunerAL Home	ADDRESS: Suitland Md	25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed ... should be detached for use as the burial-transit permit. Then please ... with the State Dept. of Health and Mental Hygiene prior to burial. ... removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or ... the medical examiner must be notified of ... event.

BP____

DHMH - 16 50M 4/83
(VRA 15, 4)

025083 MAR 89

1c FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 05997
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARY	V.	WORTHY	02 22 89	12:30AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	01-21-1906	83 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	P.G.	Bladensburg	YES X NO ☐	4212 53rd Ave., #1 20710

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Michael		Stablum	Louise		Shortal

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	----------	579-48-2551	7509 Buchanan Street Mary Bartnick, Landover Hills, Md. 20784

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) _____ — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia, Bilateral — 1 day

DUE TO, OR AS A CONSEQUENCE OF (c) Massive Stroke — 4 mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Urinary tract infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-23-88 to 2-22-89 that (I) (we) last saw the deceased alive on 2-22-89 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (was) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William D. Rosson	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR X STAFF PHYSICIAN ☐	2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William D. Rosson	5701 85th Ave., New Carrollton, Md. 20784

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	02-24-89	Ft. Lincoln Cemetery	Brentwood, P.G., Md.

24. FUNERAL DIRECTOR (NAME)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland	FEB 23 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

024910 MAR -8 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 059983

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Octavia	M.	Wright	Feb. 12, 1989	11:10 A M

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	If under 1 year: Months / Days	If under 24 hrs: Hours / Min.
Female	White	May 2, 1911	77 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maine	U.S.A.		Prince George's Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Bowie	12304 Skylark La.	Homemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	P.G.	Bowie	YES ☒ NO ☐	12304 Skylark La. 20715

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
UNK.	-	Sanders	UNKNOWN		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	--------	005-05-5844A	William A. Wright	Same as # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (a)	Acute myocardial infarction	1 hour
DUE TO, OR AS A CONSEQUENCE OF (b)	Ischemic heart disease	5 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify (not (I) (this hospital) attended the deceased from JAN 1 19 88 to FEB 12 19 89, that (I) (we) last saw the deceased alive on 12/13 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Nelson G. Goodman MD	MD		2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
NELSON G. GOODMAN MD	3231 Superior La. Bowie, MD. 20715

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	2/14/89	Chambers Crematory	Riverdale P.G. MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W.W. Chambers Co. Inc.	5801 Cleveland Ave. Riverdale Md. 20737	FEB 15 '89	Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

(3)

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023728 FEB 22 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 005999

1. DECEASED NAME (TYPE OR PRINT): FIRST Nellie MIDDLE Bell LAST Kinney Yancey
(Nellie) (Yancey)

2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☑ MONTH 2 DAY 11 YEAR 1989 — 2b. HOUR M

3. SEX Female (Female) — 4. RACE Black — 5. DATE OF BIRTH MONTH April DAY 4 YEAR 1901 — 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

7c. DATE PRONOUNCED DEAD MONTH 2 DAY 11 YEAR 1989 — 7d. HOUR 437 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia — 7b. CITIZEN OF WHAT COUNTRY? United States — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.

10. CITY OR TOWN OF DEATH Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker — 12b. KIND OF BUSINESS OR INDUSTRY Domestic

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland — 13b. COUNTY Prince Georges — 13c. CITY OR TOWN Landover — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS 8907 Ardwick Ardmore Road (20785)

14. FATHER'S NAME FIRST John MIDDLE LAST Tinsley — 15. MOTHER'S MAIDEN NAME FIRST Susie MIDDLE LAST Kinney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. 228-42-9708 — 17. INFORMANT Peyton Randolph Yancey (husband) & Hester Jones (daughter) ADDRESS 8907 Ardwick Ardmore Road, Landover, Md. 20785

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetes autonomic pleuritic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Augusto P. Rodriguez M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 2-12-89

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. — ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — 23b. DATE Feb. 18, 1989 — 23c. NAME OF CEMETERY OR CREMATORY Yancey Family Cemetery — 23d. LOCATION CITY OR TOWN Louisa COUNTY STATE Virginia

24. FUNERAL DIRECTOR NAME LATNEY'S FUNERAL HOME — ADDRESS 3831 Georgia Avenue, N.W.; Washington, D.C. 20011 — 25a. DATE REC'D. BY REGISTRAR FEB 22 1989 — 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randolph

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

022959 FEB

FOR STATE REGISTRAR UNKNOWN 89-25

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 6 2 0 2

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MARK — MIDDLE: — LAST: YEAGER

2a. DATE OF DEATH: KNOWN XX ESTIMATED ☐ — MONTH: 2 — DAY: 6 — YEAR: 1989 — 2b. HOUR:

3. SEX: Male — 4. RACE: black — 5. DATE OF BIRTH: MONTH 6 DAY 9 YEAR 66 — 6. AGE (IN YEARS LAST BIRTHDAY): 22 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 6 YEAR 1989 — 2d. HOUR: 12:48 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C. — 7b. CITIZEN OF WHAT COUNTRY?: United States — 8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Prince Georges County MD.

10. CITY OR TOWN OF DEATH: Cheverly — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Prince Georges General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: PG — 13c. CITY OR TOWN: Palmer Park — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 1909 Allendale Court 20785

14. FATHER'S NAME — FIRST: Edward — MIDDLE: — LAST: Crawford

15. MOTHER'S MAIDEN NAME — FIRST: Lossie — MIDDLE: — LAST: Randolph

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): N/A — 16b. SOCIAL SECURITY NO.: 220-90-5597 — 17. INFORMANT ADDRESS: Lossie Yeager/1909 Allendale Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Stab wound of left chest
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 2-6-89 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Subject stabbed

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): apartment — 21f. LOCATION STREET: 3213 75th Avenue, CITY OR TOWN: Landover, COUNTY: Prince Georges County, STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes — TITLE (SPECIFY) M.D.: Acting Deputy Cheif MEDICAL EXAMINER — DATE SIGNED: 2-6-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes,M.D. — ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 11 Feb 89 — 23c. NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park — 23d. LOCATION CITY OR TOWN: Landover — COUNTY: PG — STATE: MD

24. FUNERAL DIRECTOR NAME / ADDRESS: JB Jenkins FH/7474 Landover RD. Landover, MD

25a. DATE REC'D. BY REGISTRAR: FEB 13 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0024871 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 06001

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): First George; Middle L.; Last Zitt

2a. DATE OF DEATH: Month 2; Day 16; Year 89

2b. HOUR: 7P M

3. SEX: Male

4. RACE: Caucasian

5. DATE OF BIRTH: Month 6; Day 12; Year 06

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Prince George MD.

10. CITY OR TOWN OF DEATH: Laurel

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Greater Laurel Bettsville Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Printer

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Prince George

13c. CITY OR TOWN: Laurel

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET ADDRESS: 14231 Greenview Drive 20708

14. FATHER'S NAME: First William; Middle; Last Zitt

15. MOTHER'S MAIDEN NAME: First Catherine; Middle; Last ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 268-05-9182

17. INFORMANT: Dianne Purkiser

ADDRESS: 14241 Greenview Dr. Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Massive Right Hemisphere Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-13 19 89 to 2-16 19 89, that (I) (we) last saw the deceased alive on 2-16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B.K. Lance, M.D.

DEGREE: M.D.

ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-16-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Barry K. Lance, M.D.

22e. ADDRESS: 14201 Laurel Park Drive, Suite 223 Laurel, MD 20707

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal

23b. DATE: 2/21/89

23c. NAME OF CEMETERY OR CREMATORY: Howard U. Med. School

23d. LOCATION: CITY OR TOWN; COUNTY; STATE: Washington, D. C.

24. FUNERAL DIRECTOR: NAME Sam Butler Funeral Service; ADDRESS 716 Kennedy St. N. W. Washington, DC.

25a. DATE REC'D. BY REGISTRAR: MAR 06 1989

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

023025 FEB 16

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

S.F. NO. 89-006002

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
CHARLES	Albert	ZOERNER	02-08-89	5 00 AM M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	March 21, 1915	73 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington DC	USA		PRINCE GEORGE'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	PRINCE GEORGE'S HOSPITAL CENTER	Bookkeeper	Real Estate

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	PG	Landover Hills	YES X NO ☐	4117 71st Ave., 20784

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	J.	Zoerner	Lucy		Bowen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW-2	578-01-6250	Mrs. Rowena Zoerner, Same as Line #13	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Recurrent CHF	5 mo
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Artery Disease	5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐	19	

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/17/89, 19__, to 2/8, 19 89, that (I) (we) last saw the deceased alive on 2/7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Mark Wish	ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARK WISH.	PRINCE GEORGE'S HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-10-89	Ft. Lincoln Cemetery	Brentwood, P.G., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Md.	FEB 9 '89	Julia Davidson-Kendrick

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

25245 MAR 14 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 1

DHMH - 1650M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006003

1. DECEASED NAME (TYPE OR PRINT) FIRST: ~~Bernard~~ MIDDLE: Bernhard LAST: BAKKER				2a. DATE OF DEATH MONTH DAY YEAR: February 22, 1989	2b. HOUR: 9:55 A M
3. SEX: Male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: July 3, 1892	6. AGE (IN YEARS LAST BIRTHDAY): 96 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Germany	7b. CITIZEN OF WHAT COUNTRY?: Don't know	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Anne Co MD.		
10. CITY OR TOWN OF DEATH: Centreville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Corscia Hills (Meridan) Nur. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Queen Anne Co	13c. CITY OR TOWN: Chestertown	13d. INSIDE CITY LIMITS? YES ☐ NO XX	13e. STREET ADDRESS: Rte # 1 Box 607 21620	
14. FATHER'S NAME FIRST: Minneou MIDDLE: Bakker LAST:			15. MOTHER'S MAIDEN NAME FIRST: MIDDLE: LAST: Don't know		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217 36 0486	17. INFORMANT: Emma B. Bakker	ADDRESS: Rte # 1 Box 607 Chestertown, Md. 21620		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8-12 19 87 to 2-22 19 89, that (I) (we) last saw the deceased alive on 2-21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert W. Farr DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert W. Farr — 22e. ADDRESS: Chestertown, Maryland 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/25/89	23c. NAME OF CEMETERY OR CREMATORY: Crumpton, Cemetery	23d. LOCATION CITY OR TOWN: Crumpton, COUNTY: Maryland STATE:
24. FUNERAL DIRECTOR NAME: J. Willis Wells	ADDRESS: Chestertown, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 23 '89	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

025393 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060041 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Melvin Allen Chance			2a. DATE OF DEATH MONTH DAY YEAR: February 23, 1989	2b. HOUR: 4:15 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 11, 1889	6. AGE (IN YEARS LAST BIRTHDAY): 99 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wye Island MD	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Anne's Co. MD.	
10. CITY OR TOWN OF DEATH: Centreville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Q.A.	13c. CITY OR TOWN: Price	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: Box 97-M 21623
14. FATHER'S NAME FIRST / MIDDLE / LAST: Josiah Chance			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Sarah Elizabeth Melvin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-36-5757	17. INFORMANT ADDRESS: John M. Chance, Box 78, Church Hill, MD 21623	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio Resp. Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Anorexia

DUE TO, OR AS A CONSEQUENCE OF (c): Renal failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Eric F. Ciganek, MD	22e. ADDRESS: 109 S. Commerce St., Centreville, MD 21617	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 02/25/89	23c. NAME OF CEMETERY OR CREMATORY: Church Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Church Hill Q.A. MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: Tom Helfenbein Funeral Homes, Church Hill, MD 21623		25a. DATE REC'D. BY REGISTRAR: FEB 28 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

24930 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 006005

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
HOWARD	B.	COPPER	February 19, 1989	6	A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	white	May 10, 1911	77 Yrs YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Delaware	USA		Queen Anne MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Centreville	Corscia Hills (Meridan) Nursing Center		Farming	Mainteance	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Kent	Chestertown	YES XX NO ☐	507 Cannon St. 21620

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Walter Copper	Emma Boone

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		217 36 1154	Louise Graham	507 Cannon St. 21620 Chestertown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Circulatory Collapse	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic cardiovascular	Years
DUE TO, OR AS A CONSEQUENCE OF (c)	disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Parkinsons Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 3/9, 19 88, to 2/19, 19 89, that (I) (we) last saw the deceased alive on 2/7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	Feb 20, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C. Gottfried Baumann, M.D.	Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Feb 21 1989	Chester Cemetery	Chestertown, Md. 21620

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J. Willis Wells	J. Willis Wells Chestertown, Md.	FEB 21 89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15. 4)

1022944 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06006
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): FIRST Nannie MIDDLE LAST Handy
2a. DATE OF DEATH: MONTH DAY YEAR February 4, 1989
2b. HOUR: 6:15 P.M.
3. SEX: Female
4. RACE: Colored
5. DATE OF BIRTH: MONTH DAY YEAR 8- 8- 03
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Stevensville, Md
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Annes MD.
10. CITY OR TOWN OF DEATH: Centreville, Md
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Corsica Hall Meriden Nursing Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired - Domestic
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Queen Annes
13c. CITY OR TOWN: Grasonville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Melvin Avenue 21638

14. FATHER'S NAME: FIRST James MIDDLE A. LAST Clay Turner
15. MOTHER'S MAIDEN NAME: FIRST Mabel MIDDLE LAST Stansbury
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 221-01-8367
17. INFORMANT: Brenda A. Young ADDRESS: 343-37 132nd St. Rosedale, N.Y. 11422

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary failure
DUE TO, OR AS A CONSEQUENCE OF (b): Aspiration pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c): Tardive Dyskinesia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Parkinson's Disease, Diabetes, HTN

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/1 19 89 to 2/4 19 89, that (I) (we) last saw the deceased alive on 2/3 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Jay Johnson MD DEGREE
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/6/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Gary Browse
22e. ADDRESS: PO Box 210 Queenstown, MD 21658

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-9-89
23c. NAME OF CEMETERY OR CREMATORY: Rolling Green Mem. Pk
23d. LOCATION CITY OR TOWN: West Chester COUNTY: Chester STATE: Pa.
24. FUNERAL DIRECTOR (NAME): Gee Funeral Home, P.A. ADDRESS: Elkton, Md.
25a. DATE REC'D. BY REGISTRAR: FEB 13 1989
25b. REGISTRAR'S SIGNATURE: Julia Smith Bailey

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023590 FEB 23 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060007 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Regina MIDDLE: A. LAST: Hopkins	2a. DATE OF DEATH MONTH: 2 DAY: 2 YEAR: 89	2b. HOUR: 248 pM	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: March DAY: 24, YEAR: 1891	6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Annes County MD.
10. CITY OR TOWN OF DEATH: Sudlersville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Kitty's Domiciliary Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Delaware	New Castle	Wilmington	YES ☐ NO ☒	2708 Old Milltown Road

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Matthew / Walz	Elizabeth / Walz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.	---------	222-18-9282	Mr. Richard R. Hopkins, Sr.	2708 Old Milltown Wilm., Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) a S C V D
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs +

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-21 19 88, to 2-2 19 89, that (I) (saw) last saw the deceased alive on 2-2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (saw) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John R Smith Jr	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-4-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John R. Smith, Jr	Centreville Md 21617

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 6, 1989	Bethel Cemetery	Chesapeake City, Cecil Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	26. REGISTRAR'S SIGNATURE
R.T. Foard F.H., Chesapeake City, Maryland	FEB 22 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

023087 FEB 17 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06003
REG. NO.

FOR STATE REGISTRAR: Nannie M. Kaleini

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: NANNIE	MIDDLE: M	LAST: KALEINI	2a. DATE OF DEATH MONTH: 2	DAY: 14	YEAR: 89	2b. HOUR: 10 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: June	DAY: 26,	YEAR: 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Queen Anne MD.				
10. CITY OR TOWN OF DEATH: Centerville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Seamstress	12b. KIND OF BUSINESS OR INDUSTRY: Clothing			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Queen Anne	13c. CITY OR TOWN: Sudlersville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt #1 Box 29B	21668		
14. FATHER'S NAME FIRST: =====	MIDDLE	LAST: Stanley	15. MOTHER'S MAIDEN NAME FIRST: Ida	MIDDLE	LAST: =====		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 225-03-4789	17. INFORMANT: Debra M. Smith	ADDRESS: Same as 13e			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa.

① Parkinsons Disease ② Congestive Heart Failure ③ Old CVA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from June 25 19 85 to February 14 19 89 that (I) (we) last saw the deceased alive on 1/28 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H. H. Chen	DEGREE: MD.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): KIN KUE WUN	22e. ADDRESS: 216 High St, Chestertown, Md 21620		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/17/89	23c. NAME OF CEMETERY OR CREMATORY: Lake View Mem Park	23d. LOCATION CITY OR TOWN: Sykesville	COUNTY: Carroll STATE: Md
24. FUNERAL DIRECTOR: George J. Gonce	ADDRESS: 4001 Ritchie Hgwy Balto Md 21225	25a. DATE REC'D. BY REGISTRAR: FEB 15 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023458 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 6 0 1 0

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH / ESTIMATED	MONTH	DAY	YEAR	2b. HOUR			
	Richard	George	Meyer	XX / ☐	2-	3-	19 89		M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	03/03/51	37 YRS.						2-	3-	19 89	2:00 P	M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH										
Rochester, NY	U.S.A.		Queen Annes County MD.										
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY										
Chester	Route 50, Piney Narrows Road	Electrical Engineer											

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Gaithersburg	YES ☐ NO ☐	915 Wild Forest Drive

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
George Meyer	Mildred Widmer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	088-44-0645	Mildred Meyer, 95 Hardison Rd., Rochester N.Y. 14617

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	1:46PM 2-3-89 19	Passenger in auto/auto collision

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	Road	Route 50 and Piney Narrows Road, Chester, Queen Annes Co. MD

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Acting Deputy Chief TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED 2-4-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	02/09/89	Riverside Cemetery	Rochester Monroe New York

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tom Helfenbein Funeral Home, Chester, MD 21619	FEB 06 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP 6

DHMH - 17 (VR A15 ME (5))

024638 MAR 389 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06011 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be removed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Oscar	nmn	SWANN	February 17, 1989	5:00 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	September 15, 1893	95 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	United States		Queen Anne's MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Centreville	R.D. 4, Box 129, Recovery		Farmer (ret.)	Farming	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	QueenAnne's	Centreville	YES ☐ NO ☒	R.D. 2, Box 66, 21617

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James	H.	Swann	Georgia	nmn	Curry

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I	215 -36- 2385	Grandson	R.D.4, Box 129 Claude W. Hall, Jr., Recovery, Centreville, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) ascvd — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1963, to Feb. 17, 1989, that (I) (we) last saw the deceased alive on Jan. 19, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was not~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John R Smith Jr	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John R. Smith, Jr., M.D.	Centreville, Maryland 21617

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 19, 1989	Chesterfield Cemetery	Centreville, QueenAnne's, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Barton Funeral Home James H. Barton, Jr., Centreville, Md. 21617	FEB 21 '89	Julia Davidson-Randall

BP 3

DHMH - 16 50M 4/83 (VRA 15, 4)

022808 FEB 15 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006012

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Dorothea	Barrows	WITHINGTON	February 1, 1989	945a M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	November 5, 1891	97 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Illinois	USA		Queen Anne's MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Centreville	R.D. 4, Box 135	Wife	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	QueenAnne's	Centreville	YES ☐ NO ☒	R.D. 4, Box 135 21617

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Walter	Manning	Barrows	Mary	Dewey	Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		WA - 479 863	Son	P.O.Box 386 Charles F. Withington, Centreville, Md. 21617

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chronic Lymphocytic Leukemia	6 mos +
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCUS	3 yrs +
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from July 1, 1983 to Feb. 1, 1989, that (I) (we) last saw the deceased alive on Feb. 1, 1989 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John R Smith Jr	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-1-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John R. Smith, Jr	Centreville MD 21617

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb. 2, 1989	Cedar Hill Crematory	Suitland, Prince George's, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Barton Funeral Home James H. Barton, Jr., Centreville, Md. 21617	FEB 02 '89	Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 4/83
(VRA 15, 4)

023677 FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 060 13 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: RUBY	MIDDLE: MAY ELIZABETH	LAST: ALLGOOD	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR: FEB. 15 19 89	2b. HOUR: 5:00 A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JULY 1, 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: FEB. 15, 19 89	2d. HOUR: 6:30 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ST. MARY'S MD.			
10. CITY OR TOWN OF DEATH: LEXINGTON PARK	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 104 STONEY BROOK DRIVE	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BEAUTICIAN	12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: CALVERT	13c. CITY OR TOWN: NORTH BEACH	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 3912 2ND STREET 20714		
14. FATHER'S NAME FIRST / MIDDLE / LAST: GEORGE / / THORNBURG			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: MARTHA / / DAVIDSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): 1944-1945	16b. SOCIAL SECURITY NO.: 240-20-4942	17. INFORMANT ADDRESS: EDITH C. WALSH, 3306 BUCHANAN ST., APT. 201 MT. RAINIER, MD. 20712				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Viral gastroenteritis - suspected Influenza
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Senile Dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ M.D. _____ TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 2/15/89

EXAMINER'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D. ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/17/89	23c. NAME OF CEMETERY OR CREMATORY: MARYLAND VETERANS	23d. LOCATION CITY OR TOWN / COUNTY / STATE: CHELTENHAM, P.G., MARYLAND
24. FUNERAL DIRECTOR NAME / ADDRESS: EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		25a. DATE RECD. BY REGISTRAR: FEB 17 89	25b. REGISTRAR'S SIGNATURE: Juha Davidson Registrar

BP 6+1

DHMH - 17
(VR A15 ME (5))
20M 4/82

#2ak per me 054 2/23/89 km
Film G649 3/14/88 km
#18,20,21abcdefg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

023670 FEB 26 89

FOR STATE REGISTRAR

REG. NO. 89 006014

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1-2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-5. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST		2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH	DAY	YEAR 19	2b. HOUR M
Joan	Beverly	Taylor Aud		2-5	4	89	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR 19	2d. HOUR M
FEMALE	WHITE	NOV.27,1951	37 YRS.					2-5	4	89	8:00 A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	9. BALTIMORE CITY OR COUNTY OF DEATH				
MD.	U.S.A.		St. Mary's County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Hollywood	Box 37-B	CASHIER	GROCERY STORE				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST.MARY'S	HOLLYWOOD	YES [ ] NO [ ]	RT. 1, BOX 759/20636

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
EMERSON	R.	TAYLOR	GRACE	E.	NORRIS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		577-72-2125	GRACE E. GIBSON, SAME AS 13E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute combined drug intoxication

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	24-89 19	unknown

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	home	Box 37-B,	Hollywood,	St.Mary's,	Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X].

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-5-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2-08-89	ST.MICHAEL'S	RIDGE,	ST.MARY'S CO.	MD.

24. FUNERAL DIRECTOR NAME AND ADDRESS MATTINGLEY-GARDINER FUNERAL HOME,P.A. P.O.BOX 270,LEONARDTOWN,MD.20650

25a. DATE REC'D. BY REGISTRAR FEB 23 1989

25b. REGISTRAR'S SIGNATURE [signature]

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

023684 FEB 2 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060 15 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JOHN / WARREN / BARNES	2a. DATE OF DEATH MONTH DAY YEAR	February 11, 1989	2b. HOUR 6:00 PM
3. SEX	MALE	4. RACE	BLACK	5. DATE OF BIRTH MONTH DAY YEAR: JAN. 23, 1928
6. AGE (IN YEARS LAST BIRTHDAY)	61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH	St. Mary's County MD.			
10. CITY OR TOWN OF DEATH	Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER; 12b. KIND OF BUSINESS OR INDUSTRY: FARM
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE	MD.	13b. COUNTY	ST. MARY'S	13c. CITY OR TOWN: LEXINGTON PARK; 13d. INSIDE CITY LIMITS? YES [ ] NO [ ]; 13e. STREET ADDRESS: P.O. BOX 1567, WILLOWS RD. 20653
14. FATHER'S NAME FIRST / MIDDLE / LAST	FRANCIS / XAVIER / BARNES	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	QUEENIE / VIOLA / SMITH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 220-26-4270; 17. INFORMANT ADDRESS: MARY LOUISE BARNES, SAME AS 13E.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic ca of Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/30, 19 89, to 2/11, 19 89, that (I) (we) last saw the deceased alive on 2/11, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/13/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Youngsik Moon, M.D.	22e. ADDRESS: Hollywood, Md. 20636	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-15-89	23c. NAME OF CEMETERY OR CREMATORY: IMMACULATE HEART OF MARY CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: LEXINGTON PARK, ST. MARY'S, MD.
24. FUNERAL DIRECTOR NAME: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650		25. DATE REC'D. BY REGISTRAR: FEB 14 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

024483 MAR 2 0

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006016

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the application for transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes," Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: CLAUDE	MIDDLE: A	LAST: BARROW	2a. DATE OF DEATH MONTH DAY YEAR: 2 14 89	2b. HOUR: 5 17 P M
3. SEX: M	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 02 12 18	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N. CAROLINA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ST. MARY'S MD.	
10. CITY OR TOWN OF DEATH: CHARLOTTE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CHARLOTTE HALL VETERANS	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: DEPT. OF DEFENSE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: HOWARD	13c. CITY OR TOWN: COLUMBIA	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 10449 OWEN BROWN RD 21044
14. FATHER'S NAME FIRST: ROBERT	MIDDLE: D.	LAST: BARROW	15. MOTHER'S MAIDEN NAME FIRST: ELLA	MIDDLE:	LAST: BRAEHM
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): W.W. II	16b. SOCIAL SECURITY NO.: 239-01-8102	17. INFORMANT: EVELYN A. BARROW	ADDRESS: 10449 OWEN BROWN RD. COLUMBIA MD 21044	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ASPIRATION PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF (c): ALZHEIMER'S DISEASE

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D.	DEGREE: M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN H WEIDER M.D.	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-17-89	23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL	23d. LOCATION CITY OR TOWN: ARLINGTON COUNTY: STATE: VA	
24. FUNERAL DIRECTOR NAME: HARRY H. WITZKE INC. ADDRESS: 4112 COLUMBIA RD 21043 ELLICOTT CITY MD		25a. DATE REC'D BY REGISTRAR: FEB 16 89	25b. REGISTRAR'S SIGNATURE: [signature] Davidson-Randall	

BP 25

DHMH - 16 50M 4/82
(VRA 15, 4)

023676 FEB 20 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

89 REG. NO. 06017

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
MARIAN	DILLIA	BESHORE

2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐ MONTH DAY YEAR: FEB. 16, 19 89 — 2b. HOUR: 1:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	SEPT. 20, 1904	84 YRS.				

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: FEB. 16, 19 89 — 2d. HOUR: 1:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
PENNSYLVANIA	U.S.A.		ST. MARY'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LEONARDTOWN	ST. MARY'S HOSPITAL	HOUSE KEEPER	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	ST. MARY'S	LEONARDTOWN	YES ☐ NO ☒	P.O. BOX 175	20650

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JACOB	B.	BESHORE	DILLIA		GROSS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		185-28-0197	MARY LOUISE CLARK, LEONARDTOWN, MD. 20650	P. O. BOX 330

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Dpt MEDICAL EXAMINER DATE SIGNED 2/17/89.

EXAMINER'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, II, M.D. ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2/20/89	LUTHERAN	MANCHESTER,	YORK,	PENNSYLVANIA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 17 '89	Julia Davidson-Randall

BP 3

DHMH - 17
(VR A15 ME (5))
20M 4/82

0 2 3 6 8 1 FEB 2 6 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 0 6 0 1 3

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR	2b. HOUR
LAURA	VIRGINIA	BOWMAN	FEB. 10, 89	1845 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
FEMALE	WHITE	APRIL 1, 1903	85 YRS.			Feb 10 19 89	1845 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
OXON HILL, MD.	U.S.A.		ST. MARY'S MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LEONARDTOWN	ST. MARY'S HOSPITAL	HOME MAKER	HOME

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
MD.	ST. MARY'S	LEONARDTOWN		STAR RT. BOX 83-1F 20650

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WILLIAM	T.	PUMPHREY	MARY	E.	LANHAM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
N/A		577-03-5460	SON/STAR RT. BOX 83-1F JOHN WAYNE BOWMAN/LEONARDTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction 20650

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ M.D. _____ TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED 2/13/89

EXAMINER'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D. ADDRESS LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/13/89	FORT LINCOLN CEMETERY	BRENTWOOD P.G. MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A./LEON, MD.	FEB 14 89	Julia Davison Register

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 12

DHMH - 17 (VR A15 ME (5))

024623 MAR 3 89

Items18athru22a per M.E. FilmC650

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE REGISTRAR USE ONLY: 1 UNKNOWN 89-31 3/7/89 CG

REG. NO. 89 006019

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE BY WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
Dale	Martin	Brooks

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] MONTH DAY YEAR: 2-17-89 — 2b. HOUR: M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 1 YR. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN
MALE	Black	June 09 1962	26 YRS.				

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR: 2-17-1989 — 2d. HOUR: 9:00 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	USA		St. Mary's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Lexington Park	16 Lisa Court	Printer	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Calvert	Lusby	YES [ ] NO [X]	Box 48 20657

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Arthur		Brooks	Elizabeth	Weems	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	217-80-5776	Elizabeth Weems Brooks Box 48 Lusby, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke and soot inhalation and thermal injuries
Conditions, if ony, which gave rise to immediate couse (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	3:13AM 2-17-89	Victim of trailer fire

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	trailer home	16 Lisa Court, Lexington Park, St. Mary's County, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ].

ACTUAL SIGNATURE Mario F. Golle Jr. TITLE (SPECIFY) Assistant MEDICAL EXAMINER — DATE SIGNED 2-17-89

VC EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle,Jr.,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 20-89	St. Johns Chr. Cem.	Lusby	Calvert	Md

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Spencer E. Sewell	1451 Dares Beach Road Prince Frederick, Md	MAR 02 1989	Gloria Davidson-Randall

07/84 25M BP 387

DHMH - 17 (VR A15 ME (5))

024888 MAR 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06020 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES	MIDDLE: ELMER	LAST: BUCKLER	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 25, 1989
2b. HOUR: M			
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 1, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ST. MARY'S CO. MD.
10. CITY OR TOWN OF DEATH: MECHANICSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ST HOME, RT. 5, BOX 82	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: ST.MARY'S	13c. CITY OR TOWN: MECHANICSVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: RT. 5, BOX 82/20659			
14. FATHER'S NAME FIRST: THOMAS	MIDDLE	LAST: BUCKLER	15. MOTHER'S MAIDEN NAME FIRST: BERTIE
MIDDLE: MAY	LAST: COPSEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES-ARMY	(IF YES, GIVE WAR OR DATES): WW 11	16b. SOCIAL SECURITY NO.: 577-28-5183	17. INFORMANT ADDRESS: BERNARD L. BUCKLER, RT. 5, BOX 179, MECHANICSVILLE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): LYMPHOMA, PARKINSON'S DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 10-9-78 19____, to 2-25-89 19____, that (I) (we) last saw the deceased alive on 2-3-89 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John L Bennett	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-28-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN L. BENNETT, M.D.	22e. ADDRESS: CALIFORNIA, MD. 20619		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 3-01-89	23c. NAME OF CEMETERY OR CREMATORY: TRINITY MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN: WALDROF, COUNTY: CHARLES, STATE: MD.
24. FUNERAL DIRECTOR NAME AND ADDRESS: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	25a. DATE REC'D BY REGISTRAR: FEB 28 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 15+1

DHMH - 16 50M 1/81 (VRA 15, 4)

024881 MAR-8 '89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06021
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: Type the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARY	HAYDEN	BURROUGHS	FEBRUARY 19, 1989	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JUNE 24, 1909	79 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
LOVEVILLE, MD.	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	ST. MARY'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LEONARDTOWN	ST. MARY'S NURSING CENTER	HOME MAKER	HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST. MARY'S	MECHANICSVILLE	YES ☐ NO ☒	RT. 5 BOX 197/20659

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOSEPH	DENT	HAYDEN	MARY	PRISCILLA	BOWLES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
N/A		215-34-6654	SON WILLIAM M. BURROUGHS/SEVERN, MD.	446 WATTS AVE. 21144

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sec

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from JAN, 1989 to Feb 19 19 89, that (I) (we) last saw the deceased alive on Feb 3 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM D. BOYD, II, M.D.

22e. ADDRESS: LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2/22/89	ST. JOSEPH CEMETERY	MORGANZA	STM	MD.

24. FUNERAL DIRECTOR NAME: MATTINGLEY-GARDINER FUNERAL HOME, P.A. ADDRESS: P.O. BOX 270, LEONARDTOWN, MD. 20650

25a. DATE REC'D BY REGISTRAR: FEB 27 89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 2

DHMH-16 25M (VRA 15, 4) 1/79

024885 MAR 3-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 060222

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (perforated) and is the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
ALBERT	RICHARD	CLINE, SR.	FEBRUARY 24, 1989	913a. M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS: HOURS, MIN
MALE	CAUCASIAN	NOV. 21, 1913	75 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
PENNSYLVANIA	U.S.A.		ST. MARY'S MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
LEONARDTOWN	ST. MARY'S HOSPITAL	COMPUTER PROGRAMMER	U.S. GOV'T.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS	
MARYLAND	ST. MARY'S	LEONARDTOWN		P.O. BOX 161 20650	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN	RUBRIGHT	CLINE	FLORENCE		HILEMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
NO		174-07-9148	AGNES R. CLINE,	P.O. BOX 161 LEONARDTOWN, MD. 20650	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolus — hr.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8 19 80 to 2/24 19 89, that (I) (we) last saw the deceased alive on 2/24 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. PATRICK JARBOE, M.D. — 22e. ADDRESS MEDICAL ARTS BLDG., LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL	2/27/89	CHARLES MEMORIAL	LEONARDTOWN, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR NAME ADDRESS		25. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		FEB 28 89	Julia Davidson-Randall	

BP 8

DHMH-16 60M 1/73
(VR A 15 (4))

023683 FEB 2 6 '89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06023 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 8

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	JOHN / DICKERSON / COLLINS	2a. DATE OF DEATH — MONTH DAY YEAR	February 10, 1989
2b. HOUR	9:05 AM		
3. SEX	MALE	4. RACE	BLACK
5. DATE OF BIRTH — MONTH DAY YEAR	DEC. 29, 1904	6. AGE (IN YEARS LAST BIRTHDAY)	84 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS. — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MD.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	St. Mary's County MD.
10. CITY OR TOWN OF DEATH	Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	St. Mary's Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	FARMER	12b. KIND OF BUSINESS OR INDUSTRY	FARM

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST. MARY'S	ABELL	YES [ ] NO [X]	GENERAL DELIVERY/20606

14. FATHER'S NAME — FIRST / MIDDLE / LAST	ROBERT / HENRY / COLLINS	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	JANE / FRANCES / DICKERSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	NO	16b. SOCIAL SECURITY NO.	213-22-0197
17. INFORMANT — ADDRESS	MARY LOUISE COLLINS, SAME AS 13E.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/10, 19 89, to 2/10, 19 89, that (I) (we) last saw the deceased alive on 2/10, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (did not) view the body after death.

22b. SIGNATURE — DEGREE	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
		2/11/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James C. Boyd, M.D.	Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
BURIAL	2-16-89	SACRED HEART CEMETERY	BUSHWOOD, ST. MARY'S, MD.

24. FUNERAL DIRECTOR — NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	FEB 14 '89	Julia Davidson-Randall

024879 MAR-8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06024

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for the public health transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: VINCENT	MIDDLE: PAUL	LAST: CUMMINGS	2a. DATE OF DEATH MONTH DAY YEAR: February 16, 1989	2b. HOUR: 1:25p M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JAN. 26, 1929	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): CONN.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's MD.		
10. CITY OR TOWN OF DEATH: Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HANDY MAN	12b. KIND OF BUSINESS OR INDUSTRY: MARINA		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: ST.MARY'S	13c. CITY OR TOWN: CHARLOTTE HALL	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: P.O. BOX 61/20622	
14. FATHER'S NAME FIRST: EDWARD	MIDDLE	LAST: CUMMINGS	15. MOTHER'S MAIDEN NAME FIRST: ELIZABETH	MIDDLE	LAST: UNKNOWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES-AIR FORCE (IF YES, GIVE WAR OR DATES): 47-53	16b. SOCIAL SECURITY NO.: 006-24-5683	17. INFORMANT: JOSEPH DONALD THOMPSON	ADDRESS: RT. 1, BOX 207, MECHANICSVILLE, MD. 20659		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe Cardiomyopathy with Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hepatic insufficiency

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8/16, 19 88, to 2/16, 19 89, that (I) (we) last saw the deceased alive on 2/16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) examine the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James C. Boyd M.D.

22e. ADDRESS: Leonardtown, MD 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 2-23-89	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY	23d. LOCATION CITY OR TOWN: SUITLAND, COUNTY: P.G. STATE: MD.

24. FUNERAL DIRECTOR NAME: MATTINGLEY-GARDINER FUNERAL HOME, P.A.
P.O. BOX 270, LEONARDTOWN, MD. 20659

25. DATE RECEIVED BY REGISTRAR: FEB 27 89

25a. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 1

DHMH - 16 50M 1/81 (VRA 15, 4)

23680 FEB 26 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06025
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21a marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
MARY	MADELINE	DEMENT	February 14, 1989	11:10 P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	WHITE	FEB. 25, 1902	86 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD.	U.S.A.		ST. MARY'S CO. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtown	St. Mary's Hospital		HOUSEWIFE	HOME	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST. MARY'S	CALLAWAY	YES ☐ NO ☐	GENERAL DELIVERY/20620

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
LOUIS		EVANS	MARGARET		LONG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		218-34-6269	MARTINA B. AUD	RT.1 BOX 537, HOLLYWOOD, MD.2063

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Min.

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure — Day

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Dz, — yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): U.T.I. + Sepsis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2/13 19 89 to 2/14 19 89, that (I) (~~my last~~ saw the deceased alive on 2/13 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did not) saw the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
J. Patrick Jarboe MD	MD		2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. Patrick Jarboe, M.D.	Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-17-89	ST.GEORGE EPISCOPAL CEM.	VALLEY LEE, ST.MARY'S, MD.

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O.BOX 270, LEONARDTOWN, MD.20650	FEB 16 89	Julia Davidson-Randall

BP 1

DHMH - 1650M 1/81 (VRA 15, 4)

023685 FEB 2 6 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 006026

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the Registrar of Vital and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
ALICE	M.	DRESHER	FEBRUARY 11, 1989	3:25a.m	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS: HOURS, MIN.
FEMALE	CAUCASIAN	APRIL 29, 1928	60 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
OKLAHOMA	U.S.A.		ST. MARY'S MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
LEXINGTON PARK	BAYSIDE NURSING CENTER	WAITRESS			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ST. MARY'S	LEXINGTON PK.	YES [X] NO [ ]	423 ESSEX DRIVE 20653

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ALEC	DAVID	CALLIHAM	ANNIE	LOUELLA	VAUGHT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		447-22-4305	RALPH E. DRESHER	423 ESSEX DRIVE, LEXINGTON PARK, MD. 20653

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Seconds

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1984, 19___, to 2-11-89, 19___, that (I) (we) last saw the deceased alive on 2-1-89, 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
WILLIAM D. BOYD, II, M.D.	17 JEFFERSON ST., LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	2/13/89	HUNTT CREMATORY	WALDORF, CHARLES, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 14 89	Julia Davidson-Randall

BP6

DHMH-16 60M 1/73
(VR A 15 (4))

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006027 REG. NO.

024 1 FEB 2 89

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JAMES	BENEDICT	DYSON	February 13, 1989	11:50 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Black	Jan. 10 1927	62 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		St. Mary's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Leonardtown	St. Mary's Hospital	Labor	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	St. Marys	St. Ingoes	YES ☐ NO ☒	Rt. 5 Gen. Del. 20684

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Thomas		Dyson	Lucy		Barnes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		216-22-2571	Sarah Dyson	Rt. 5 Gen. Del. St. Ingoes

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Renal + Hepatic failure

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-6-89, 19____, to 2-13-89, 19____, that (I) (we) last saw the deceased alive on 2/13/89 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William D. Boyd, II M.D.	Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 18-89	St. Peter Claver Cem	St. Ingoes St. Marys Md

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Spencer E. Sewell	1451 Dares Beach Road Prince Frederick, Md	FEB 17 1989	Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

023007 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06023 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M (VRA 15, 4) 1/79

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
NORA	AGNES	ENSIGN	FEBRUARY 4, 1989		M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	OCT. 14, 1901	87 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MASS.	U.S.A.		ST. MARY'S CO. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
LEONARDTOWN	ST. MARY'S NURSING CENTER		HOUSEWIFE	HOME	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST. MARY'S	ST. MARY'S CITY	YES ☐ NO ☒	P.O. BOX 374/20686

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
BENJAMIN		O'KEEFE	HANNAH		O'BRIEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		071-36-4745	JUDITH ANN ENSIGN,	SAME AS 13E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart Failure - Congestive

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia / Ischemic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/3 19 88 to 2/4 19 89, that (I) (we) last saw the deceased alive on 2/3 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Dal C Allen DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID ALLEN, M.D.	LEONARDTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-08-89	EASTLAWN CEMETERY	WILLIAMSTOWN, BERKSHIRE, MASS.

24. FUNERAL DIRECTOR NAME / ADDRESS	24a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERALHOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	FEB 08 89	Julia Davidson-Randall

022596 FEB 13 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 89

FOR 1- STATE REGISTRAR

REG. NO. 060299

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Rosie — MIDDLE: Ellen — LAST: Fitzgerald

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] — MONTH 2 DAY 2 YEAR 1989 — 2b. HOUR A M

3. SEX: Female — 4. RACE: Caucasian W — 5. DATE OF BIRTH: MONTH 1 DAY 20 YEAR 15 — 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 2 YEAR 1989 — 2d. HOUR A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kentucky — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's MD.

10. CITY OR TOWN OF DEATH: Leonardtown — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Mary's Hospital, Leonardtown — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker — 12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD — 13b. COUNTY: P. G. — 13c. CITY OR TOWN: Brandywine — 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] — 13e. STREET ADDRESS: 10505 Cedarville Rd. 20613

14. FATHER'S NAME — FIRST: William — MIDDLE — LAST: Wilson

15. MOTHER'S MAIDEN NAME — FIRST: Axie — MIDDLE — LAST: Mills

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): N/A — 16b. SOCIAL SECURITY NO.: 578-36-0634 — 17. INFORMANT: James DeBord — ADDRESS: Same as 13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Probable myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: See

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): MEDICAL EXAMINER — DATE SIGNED: 2/2/89

EXAMINER'S NAME (TYPE OR PRINT): William D. Boyd II, M.D. ADDRESS: Leonardtown, MD 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 02/06/89 — 23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, Prince George's Md.

24. FUNERAL DIRECTOR NAME: Lee Funeral Home, Inc. ADDRESS: 6633 Old Alexander Ferry Rd Clinton, Md 20735

25a. DATE REC'D. BY REGISTRAR: FEB 09 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Dawson-Lindsay

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5)
20M 4/82

024880 MAR -8 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06030 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked yes, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
VIRGINIA	LEE	GREEN	February 20, 1989	3:20PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	BLACK	APRIL 12, 1933	55 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	U.S.A.		St. Mary's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Leonardtown	St. Mary's Hospital	HOUSEWIFE	HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST. MARY'S	HELEN	YES ☐ NO ☐	GENERAL DELIVERY/20635

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
SAM		TALBERT	MARY	C.	NOLAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		213-30-8624	JOSEPH A. GREEN, SAME AS 13E.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Resp failure
DUE TO, OR AS A CONSEQUENCE OF (b) Advanced COPD, Gi Bleed
DUE TO, OR AS A CONSEQUENCE OF (c) MTN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
B. Jhaveri	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
B. Jhaveri, M.D.	Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-24-89	CHARLES MEMORIAL GARDENS	LEONARDTOWN, ST. MARY'S, MD.

24. FUNERAL DIRECTOR NAME AND ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O.BOX 270, LEONARDTOWN, MD. 20650	FEB 27 '89	Julia Davidson-Randall

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

024876 MAR-8 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06031

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JAMES	NEARY	GUY	FEBRUARY 18, 1989	11:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
MALE	CAUCASIAN	NOV. 17, 1913	75 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
MARYLAND	U.S.A.		ST. MARY'S MD.	FIREMAN	CIVIL SERVICE

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LEONARDTOWN	RT. #1, BOX 18B

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ST. MARY'S	LEONARDTOWN	YES ☐ NO ☒	RT. #1, BOX 18B 20650

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JAMES	WARREN	GUY SR.	ESTELLE		LONG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		213-14-0303	MRS. MARY ANNETTE GUY, LEONARDTOWN, MD.	RT. #1, BOX 18B

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia - Probable — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Multiple Cerebrovascular Accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 12/8, 19 88, to 2/18, 19 89, that (I) (we) last saw the deceased alive on 2/18, 19 89, and that to the (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID C. ALLEN, M.D.	LEONARDTOWN, MARYLAND 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/23/89	ST. ALOYSIUS	LEONARDTOWN, ST. MARY'S, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 21 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH 1660M 1/73
(VR A 15 (4))

0251 43 MAR 10 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06032
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST GWYNN; MIDDLE MARIE; LAST HARDING
2a. DATE OF DEATH: MONTH February; DAY 18; YEAR 1989
2b. HOUR: 5:10 AM
3. SEX: FEMALE
4. RACE: CAUCASIAN
5. DATE OF BIRTH: MONTH FEB.; DAY 18; YEAR 1989
6. AGE (IN YEARS LAST BIRTHDAY): YRS.; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS 1, MIN. 41
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: ST. MARY'S MD.
10. CITY OR TOWN OF DEATH: LEONARDTOWN
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ST. MARY'S HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ----------
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: ST. MARY'S
13c. CITY OR TOWN: LEXINGTON PK.
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 511 HANCOCK ROAD 20653

14. FATHER'S NAME: FIRST JAMES; MIDDLE RICHARD; LAST HARDING
15. MOTHER'S MAIDEN NAME: FIRST ROBERTA; MIDDLE LEA; LAST O'DONNELL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: ----------
17. INFORMANT: ROBERT J. O'DONNELL, ADDRESS 511 HANCOCK ROAD, LEXINGTON PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 21-22 wks gestational age immature — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Nonviable fetus (female)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/18/89 to ____ 19____, that (I) (we) last saw the deceased alive on 2/18/89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Kiritkumar Patel
DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2-20-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Kiritkumar Patel, M.D.
22e. ADDRESS: Leonardtown, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 2/22/89
23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN MEMORIAL
23d. LOCATION: CITY OR TOWN LEXINGTON PARK; COUNTY ST. MARY'S; STATE MD.
24. FUNERAL DIRECTOR: NAME AND ADDRESS: EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.
25a. DATE REC'D. BY REGISTRAR: MAR 07 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

024167 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06033
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The original and carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, (violent, traumatic event), the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert	MIDDLE: K.	LAST: Hodgens	
2a. DATE OF DEATH MONTH DAY YEAR: 2/5/89	2b. HOUR: 458 AM		
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: August 29, 1927	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Massachusetts	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County, MD.
10. CITY OR TOWN OF DEATH: Charlotte Hall	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Charlotte Hall Veterans Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Technician	12b. KIND OF BUSINESS OR INDUSTRY: Office Machines
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Maryland	13b. COUNTY: MOntgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES XX NO ☐ — 13e. STREET ADDRESS: 112 Calvert Road/20850
14. FATHER'S NAME FIRST: James	MIDDLE: A.	LAST: Hodgens	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: not available
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): World War II	16b. SOCIAL SECURITY NO.: 579-28-4784	17. INFORMANT ADDRESS: Deborah A. Valentine same as line 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) XXXXXX attended the deceased from December 18, 19 87, to February 5, 19 89, that (I) XX last saw the deceased alive on January 10, 19 89, and that in (my) XX opinion death occurred on the date and hour and from the causes stated above, (I) XXXX (did not) view the body after death.

22b. SIGNATURE: JDW — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-5-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Jonathan Lowenthal, M.D.

22e. ADDRESS: Rts. 2 & 4, Box 262-C, Prince Frederick, Maryland 20678

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	February 6, 1989	Montgomery Crematorium, Inc.	Bethesda/Montgomery/Maryland

24. FUNERAL DIRECTOR: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850

25a. DATE REC'D. BY REGISTRAR: FEB 06 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 441

DHMH - 16 50M 4/82
(VRA 15, 4)

024878 MAR 18 1989

STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 006034 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 4

DHMH - 17
(VR A15 ME (5))
20M 4/82

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
ELOISE	BOBBIE	JONES

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] — MONTH FEB. DAY 22 YEAR 19 89 — 2b. HOUR 4 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	JULY 30, 1923	65 YRS.				

2c. DATE PRONOUNCED DEAD — MONTH FEB. DAY 22 YEAR 19 89 — 2d. HOUR 4:00 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	9. BALTIMORE CITY OR COUNTY OF DEATH
NORTH CAROLINA	U.S.A.		ST. MARY'S MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LEXINGTON PARK	BAYSIDE NURSING CENTER	SUPERVISOR	FOOD SERVICE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ST. MARY'S	PATUXENT RIVER	YES [X] NO [ ]	1551 E. LOVELL CT. 20670

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
EDWARD		BARBOUR	ALVA	MAE	WEST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	W.W.II	013-20-9777	SHANNON KELLY, 1551 E. LOVELL CT. PATUXENT RIVER, MD. 20670

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma of the Pancreas	Months.
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) D & T MEDICAL EXAMINER DATE SIGNED 2/02/89

EXAMINER'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, II, M.D. ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2/24/89	COLONIAL GROVE MEM. PK.	VIRGINIA BEACH,		VIRGINIA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 23 89	[signature]

023672 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 0 6 0 3 6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 23b is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
REGINA	HELEN	KALETA	FEBRUARY 19, 1989	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	JAN. 10, 1920	69 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
PA.	U.S.A.		ST. MARY'S CO. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LEXINGTONPARK	AT HOME, 108 GENESTA ST.	SALES PERSON	DEPT. STORE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
N.J.	CAMDEN	BELLMAWR	YES ☐ NO ☐	241 MERCER AVE. 99999

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
HENRY / MACKLIN	HELEN / CORCORIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		159-09-8593	EDWARD D. KALETA,	108 GENESTA ST. LEXINGTON PARK, MD. 20653

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of lung with Brain Metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/2, 19 88, to 2/19, 19 89, that (I) (we) last saw the deceased alive on 11/2, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JAMES C. BOYD, M.D.	LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-24-89	NEW ST. MARY'S CEM.	BELLMAWR, CAMDEN, N.J.

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	FEB 21 '89	Julia Davidson-Randall

BP 10

DHMH-16 25M (VRA 15, 4) 1/79

023689 FEB 2 6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006036
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lawrence MIDDLE: Hubbard LAST: Ketnor			2a. DATE OF DEATH MONTH DAY YEAR: February 10, 1989
2b. HOUR: 5:40P M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 04 25 1919	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Charles ST. MARY'S MD.
10. CITY OR TOWN OF DEATH: Charlotte Hall	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): residence - Meredith Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chief Eng.	12b. KIND OF BUSINESS OR INDUSTRY: Fishing Ind

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Charles ST. MARY'S	Charlotte Hall	YES ☐ NO ☒	Meredith Road 20622

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
George Fuller Ketnor	Bessie Emily Treakle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W.II	224-03-4813	Wanda L. Finazzo, Charlotte Hall, Md.	Rt.1 Box 327 A

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLON CARCINOMA

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Krishan M. Mathur	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/11/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Krishan M. Mathur, M.D.	Charles Professional Center Waldorf, Maryland 20601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-14-89	Oakland Baptist Cem.	Dalhgren, King Geo., Va.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arehart Funeral Home, Inc., La Plata, Md.	FEB 13 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and [illegible] as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If [illegible] is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

024884 MAR -8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06037
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or copied and the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
LEO	PETER	KLEAR, SR.	FEBRUARY 24, 1989	1549	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	CAUCASIAN	JAN. 09, 1907	82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
OHIO	U.S.A.		ST. MARY'S MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
LEONARDTOWN	ST. MARY'S HOSPITAL	FOREMAN	STATE ROADS		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ST. MARY'S	LEONARDTOWN	YES ☐ NO ☒	RT. #2, BOX 10 20650

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
GEORGE		KLEAR	THERESA		ZENZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	1924-1925	220-16-7826	LEO P. KLEAR, JR.,	RT. #2, BOX 10 LEONARDTOWN, MD. 20650

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sudden Death - Prob Cardiac Arrhythmia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 12, 19 88, to 2/24, 19 89, that (I) (we) last saw the deceased alive on 1/31, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did)(did not) view the body after death.

22b. SIGNATURE — DECEASED	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
		2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID C. ALLEN, M.D.	LEONARDTOWN, MARYLAND 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/28/89	ST. ALOYSIUS	LEONARDTOWN, ST. MARY'S, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 28 '89	Julia Davidson-Randall

BP 6+1

DHMH-16 60M 1/73
(VR A 15 (4))

023673 FEB 2 6 89

#8) P12MG649
FOR STATE REGISTRAR 3/8/89 Km

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06033
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or see.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARGARET MIDDLE: ABEL LAST: KNOPE		2a. DATE OF DEATH MONTH DAY YEAR: February 19, 1989	2b. HOUR: 11:38 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: OCT. 20, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] ~~WIDOWED~~ [X] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County MD.
10. CITY OR TOWN OF DEATH: Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PROCURER	12b. KIND OF BUSINESS OR INDUSTRY: U.S.GOV.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST.MARY'S	COMPTON	YES [ ] NO [X]	GENERAL DELIVERY/20627

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
JOHN / SABASTIAN	JESSIE / DENT / TURNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
N/A		577-18-3633	DAUGHTER PATRICIA ABEL WALTON/MIDDLEBURG, VA.	BOX 1286 22117

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Colon Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 19 19__ to Feb 19 19 89, that (I) (we) last saw the deceased alive on Feb 19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William D. Boyd, III	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William D. Boyd, II M.D.	Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/23/89	CHARLES MEMORIAL GARDENS/LEONARDTOWN STM	MD.

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A. ~~P.O. BOX 270, LEONARDTOWN, MD. 20650~~	FEB 21 '89	Julia Davidson-Randall

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

023010 FEB 18 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 006039

1. DECEASED NAME (TYPE OR PRINT): FIRST JOSEPH; MIDDLE ETHELBERT; LAST LANGLEY

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH FEB. DAY 4 YEAR 19 89 — 2b. HOUR 1327 M

3. SEX: MALE — 4. RACE: BLACK — 5. DATE OF BIRTH: MONTH NOV. DAY 14 YEAR 1920 — 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN

2c. DATE PRONOUNCED DEAD: MONTH FEB. DAY 4 YEAR 19 89 — 2d. HOUR 1327 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: ST. MARY'S MD.

10. CITY OR TOWN OF DEATH: LEONARDTOWN — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ST. MARY'S HOSPITAL — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): BARBER — 12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: ST. MARY'S — 13c. CITY OR TOWN: DAMERON — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: GENERAL DELIVERY 20628

14. FATHER'S NAME: FIRST JOHN; MIDDLE HENRY; LAST LANGLEY

15. MOTHER'S MAIDEN NAME: FIRST DAISY; MIDDLE; LAST BARNES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): W.W.II

16b. SOCIAL SECURITY NO.: 220-26-4682

17. INFORMANT: MARY M. LANGLEY — ADDRESS: GENERAL DELIVERY, DAMERON, MARYLAND 20628

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Probable Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Wm Boyd toms. M.D. — TITLE (SPECIFY): DPT MEDICAL EXAMINER — DATE SIGNED: 2/7/89

EXAMINER'S NAME (TYPE OR PRINT): WILLIAM D. BOYD, II, M.D. — ADDRESS: 17 JEFFERSON ST., LEONARDTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 2/8/89 — 23c. NAME OF CEMETERY OR CREMATORY: ST. PETER CLAVER — 23d. LOCATION CITY OR TOWN: ST. INIGOES COUNTY: ST. MARY'S STATE: MD.

24. FUNERAL DIRECTOR NAME / ADDRESS: EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.

25a. DATE REC'D BY REGISTRAR: FEB 07 '89 — 25b. REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP 541

DHMH - 17
(VR A15 ME (5))
20M 4/82

J24587 MAR -3 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06040 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the forbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: MADELINE	LAST: LINDSEY	2a. DATE OF DEATH MONTH DAY YEAR: February 2, 1989	2b. HOUR: 10:49 A.M.	
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 9, 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DRAYDEN	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County MD.		
10. CITY OR TOWN OF DEATH: Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ELEVATOR OPT.	12b. KIND OF BUSINESS OR INDUSTRY: UNKNOWN		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: ST.MARY'S	13c. CITY OR TOWN: DRAYDEN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: GENERAL DELIVERY/20630	
14. FATHER'S NAME FIRST: WILLIAM	MIDDLE	LAST: LANGESTER	15. MOTHER'S MAIDEN NAME FIRST: UNKNOWN	MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): N/A	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-24-2224	17. INFORMANT ADDRESS: ESTHER I. ROACH/DRAYDEN, MD. 20630		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months.
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-23-89, 19____, to 2-2-89, 19____, that (I) (we) last saw the deceased alive on 2-2-89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/4/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): William D. Boyd, II M.D.
22e. ADDRESS: Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/7/89	23c. NAME OF CEMETERY OR CREMATORY: CHARLES MEMORIAL GAR./LEONARDTOWN	23d. LOCATION CITY OR TOWN / COUNTY / STATE: STM / MD.	
24. FUNERAL DIRECTOR NAME / ADDRESS: MATTINGLEY-GARDINER FUNERAL HOME, P.A./LEONARDTOWN, MD. 20650		25a. DATE REC'D. BY REGISTRAR: FEB 08 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

023052 FEB 17 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 006041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JOHN	F	MCMAHON, JR.	02-12-89	12:00 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	Nov. 24, 1922	66 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		St. Mary's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Leonardtown	St. Mary's Hospital	Pressman	News Post

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Baltimore	Towson	YES ☐ NO ☒	204 Linden Ave. 21204

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	F.	McMahon	Margaret		Wheeler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	214-14-5889	Angela Smith - same as #13e	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) End Stage COPD

DUE TO, OR AS A CONSEQUENCE OF (c) SMOKING

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 89, to 2/12 19 89, that (I) (we) last saw the deceased alive on 2/12 19 89, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
David C. Allen	MD		2/12/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID C. ALLEN, M.D.	St. Mary's Hospital - Leonardtown, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-16-89	Most Holy Redeemer	Balto., Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ruck Towson Funeral Home, Inc., 1050 York Rd. Towson, Md. 21204	FEB 14 1989	Julia Davidson-Randall

024877 MAR -8 80 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006042 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
LOUIS	ELIJAH	MESSICK	February 18, 1989	2:10p M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	CAUCASIAN	MARCH 26, 1917	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		St. Mary's County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Leonardtown	St. Mary's Hospital	AUTO MECHANIC	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ST. MARY'S	SCOTLAND	YES ☐ NO ☒	RT. #5, BOX 65 20687

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
MAHONEY		MESSICK	SABRIE		MOORE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	W.W.II	219-07-4736	BEVERLY V. MESSICK, SCOTLAND, MD. 20687	RT. #5, BOX 65

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RENAL FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) DIFFUSE ARTERIOSCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): EMPHYSEMA, HYPERTENSION, DEPRESSION, CORONARY ARTERY DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from Feb 7, 19 89, to Feb 18, 19 89, that (I) (~~we~~) last saw the deceased alive on FEB 18 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John L Bennett MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Feb 20, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Bennett M.D.	California, MD 20619

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/21/89	ST. MICHAEL'S	RIDGE, ST. MARY'S, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 21 '89	Julia Davidson-Randall

BP 671

DHMH - 1650M 1/81 (VRA 15, 4)

023686 FEB 2 6 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06043 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	THOMAS RODNEY "MORELAND" MOLDEN	2a. DATE OF DEATH MONTH DAY YEAR	February 3, 1989	2b. HOUR	7:13 PM
3. SEX	MALE	4. RACE	BLACK	5. DATE OF BIRTH MONTH DAY YEAR	MAY 2, 1892
6. AGE (IN YEARS LAST BIRTHDAY)	96 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MD.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	St. Mary's County MD.				
10. CITY OR TOWN OF DEATH	Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	CARPENTER
12b. KIND OF BUSINESS OR INDUSTRY	CONSTRUCTION				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD.	13b. COUNTY	ST. MARY'S	13c. CITY OR TOWN	MECHANICSVILLE
13d. INSIDE CITY LIMITS?	YES ☐ NO ☒	13e. STREET ADDRESS	RT. 3 BOX 96/20659		
14. FATHER'S NAME FIRST / MIDDLE / LAST	NATHANIEL MOLDEN	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	SARAH "UNKNOWN"		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	YES	(IF YES, GIVE WAR OR DATES)	1917-1919	16b. SOCIAL SECURITY NO.	214-18-8868A
17. INFORMANT ADDRESS	AGNES M. WOODLAND, SAME AS 13E.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours.
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-2-89, 19____, to 2-3-89, 19____, that (I) (we) last saw the deceased alive on 2-3-89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED	2/7/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	William D. Boyd, II M.D.	22e. ADDRESS	Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	2-07-89	CHARLES MEMORIAL GARDENS	LEONARDTOWN, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR NAME / ADDRESS	MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	25a. DATE RECD. BY REGISTRAR	FEB 08 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

025328 MAR 16 89

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 006044 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE OFFICE OF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR 1:35 P.M.
PAUL	EDWARD	MYERS	FEB.	27,	1989	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR 12:15 P.M.
MALE	WHITE	JAN. 9, 1914	75 YRS.			FEBRUARY 27, 1989	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH				
PENNSYLVANIA	U.S.A.		ST. MARY'S MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
LEONARDTOWN	ST. MARY'S HOSPITAL	SALESMAN	AUTO				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WORCHESTER	OCEAN CITY	YES ☒ NO ☐	9400 OCEAN HIGHWAY 21842

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
EDWARD	HARRY	MYERS	ALICE	MARGARET	LONG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES WW 11	578-10-3817	PAUL EDWARD MYERS, JR.	6743 ENCHANTED VALLE RENO, NEVADA 89523

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Myocardial Infarction See
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if ony, which gove rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) MD MEDICAL EXAMINER DATE SIGNED 2/28/89

EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd II, M.D. ADDRESS Leonardtown, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	3-7-89	MD. VETERANS CEMETERY	CHELTENHAM P.G. MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
AREHART FUNERAL HOME, INC. LA PLATA, MD.	MAR 03 '89	Julia Davidson-Randall

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

024886 MAR-8 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06045 REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1/73
(VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b HOUR	
CLARENCE	EARVIN	QUARLES, SR.	FEBRUARY 22, 1989	2:05a.M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	BLACK	FEB. 11, 1934	55 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
VIRGINIA	U.S.A.		ST. MARY'S MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
LEXINGTON PARK	RT. #3, BOX 130	TRUCK DRIVER			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ST. MARY'S	LEXINGTON PK.	YES [ ] NO [X]	RT. #3, BOX 130 20653

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
GEORGE		QUARLES	MINNIE		McCOWAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		228-42-8100	MARIAN C. QUARLES,	RT. #3, BOX 130 LEXINGTON PARK, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CANCER OF
DUE TO, OR AS A CONSEQUENCE OF THE COLON
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Krishna P Jayaraman	MD	[ ] [X] [ ]	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Krishna Jayaraman, M.D.	VILLAGE MEDICAL CENTER, MECHANICSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	2/27/89	ZION UNITED METHODIST	LEXINGTON PARK, ST. MARY'S, MD.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 28 '89	Julia Davidson-Randall

BP 6

024882 MAR -8 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06046 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: THOMAS	MIDDLE: FRANKLIN	LAST: RALEY	2a. DATE OF DEATH MONTH DAY YEAR: February 20, 1989	2b. HOUR: 1:52A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 2, 1929	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County MD.		
10. CITY OR TOWN OF DEATH: Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FARMER	12b. KIND OF BUSINESS OR INDUSTRY: FARM		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST.MARY'S	MECHANICSVILLE	YES ☐ NO ☒	P.O. BOX 252/20659

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ARTHUR	E.	RALEY	JANIE	R.	BUCKLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		214-30-0551	ELEANOR BUCKLER	P.O.BOX 815,MECHANICSVILLE, MD.20659

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Chronic Alcohol abuse cirrhosis, cachexia Hypotension + severe nutritional deficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART II(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 89 to 2/20 19 89, that (I) (we) last saw the deceased alive on 2/19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	22c. DATE SIGNED
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James C. Boyd, M.D.	Leonardtown, Md. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-23-89	ALL FAITH EPISCOPAL	CHARLOTTE HALL, ST.MARY'S, MD.

24. FUNERAL DIRECTOR NAME	25. DATE RECEIVED BY REGISTRAR	26. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	FEB 27 89	

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

023310 FEB 12 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 026047

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Karen	MIDDLE: J.	LAST: Rawlings	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH: 2-11	DAY	YEAR: 1989	2b. HOUR M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 10, 1973	6. AGE (IN YEARS LAST BIRTHDAY): 15 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: 2-11 1989	2d. HOUR: 6:30 a. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County, MD.				
10. CITY OR TOWN OF DEATH: New Market	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt. 6 & Rt. 5 intersection	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student	12b. KIND OF BUSINESS OR INDUSTRY: School				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	St. Mary's	Charlotte Hall	YES XX NO ☐	P.O. Box 149 /20622

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	-	Rawlings	Nancy	-	Rawlings

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	----------	227-25-3740	Nancy Rawlings(Mother) Same as # 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Injuries
8/2/
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	5:42 XX 2-11 1989	passenger in auto/auto impact

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	road	Rt.6 & Rt. 5, New Market, St. Mary's Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: John E. Smialek
TITLE (SPECIFY): M.D. Chief MEDICAL EXAMINER
DATE SIGNED: 2-12-89
EXAMINER'S NAME (TYPE OR PRINT): John E. Smialek, M.D.
ADDRESS: 111 Penn St., Balto., Md. 21202

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 16, 1989	Ft. Lincoln Cemetery	Brentwood P.G. MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W.W. Chambers Co. Inc.	5801 Cleveland Ave. Riverdale MD. 20737	FEB 16 1989	Julia Davidson-Randall

07/84 25M BP ____ DHMH - 17 (VR A15 ME (5))

023008 FEB 16 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06048
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	THOMAS BILLINGSLY REEVES	2a. DATE OF DEATH MONTH DAY YEAR	February 6, 1989	2b. HOUR	11:42 P M
3. SEX	MALE	4. RACE	CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR	NOV. 27, 1900
6. AGE (IN YEARS LAST BIRTHDAY)	88 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	St. Mary's County MD.				
10. CITY OR TOWN OF DEATH	Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	FARMER
12b. KIND OF BUSINESS OR INDUSTRY					

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	ST. MARY'S	BUSHWOOD	YES [ ] NO [X]	STAR ROUTE, BOX 74 20618

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
THOMAS G. REEVES	KATHERINE LYON	NO		213-22-1032	MILDRED C. REEVES, STAR ROUTE, BOX 74 BUSHWOOD, MARYLAND 20618

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Congestive Heart Failure	
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/23, 19 89, to 2/6, 19 89, that (I) (we) last saw the deceased alive on 2/6, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/7/89
22d. PHYSICIAN'S NAME (TYPED OR PRINT) James C. Boyd, M.D.	22e. ADDRESS Leonardtown, Md. 20650	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/9/89	ALL SAINTS EPISCOPAL	AVENUE, ST. MARY'S, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	FEB 09 89	Julia Hudson-Randall

024107 FEB 89 S

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 006049

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: STELLA A. RITCHIE

2a. DATE OF DEATH MONTH DAY YEAR: February 11, 1989

2b. HOUR: 9:58A M

3. SEX: female

4. RACE: white

5. DATE OF BIRTH MONTH DAY YEAR: February 20, 1893

6. AGE (IN YEARS LAST BIRTHDAY): 95 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County MD.

10. CITY OR TOWN OF DEATH: Leonardtown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Mary's Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer / Factory

12b. KIND OF BUSINESS OR INDUSTRY: Mattress

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Calvert

13c. CITY OR TOWN: Solomons

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: P.O.Box 215, 20688

14. FATHER'S NAME FIRST MIDDLE LAST: Edwin Yoe Morgan

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Sarah Elizabeth Garner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES): N/A

16b. SOCIAL SECURITY NO.: 212-10-4382

17. INFORMANT: Ralph Morgan, ADDRESS 708 Lee Ave. Sykesville, Md. 21784

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: See
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia — 0 y, 5.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-27-89, 19____, to 2-11-89, 19____, that (I) (we) last saw the deceased alive on 2-10-89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William Boyd Jr. DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/13/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): William D. Boyd II, M.D.

22e. ADDRESS: Leonardtown, MD 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-14-1989

23c. NAME OF CEMETERY OR CREMATORY: Broomes Island Cem.

23d. LOCATION CITY OR TOWN COUNTY STATE: Broomes Island, Calvert, Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Donald V. Borgwardt, 4405 Broomes Isl Rd; Port Republic, Md. 20676

25a. DATE REC'D. BY REGISTRAR: FEB 17 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16.50M 1/81 (VRA 15, 4)

022448 FEB 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06050
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST George	MIDDLE Frederick	LAST Sipp	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
	George	F.	Sipp	2 - 1 - 89	745 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
M (Male)	Caw. White	12 - 7 - 98	90 YRS	+	+

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Richmond VA	USA		St. Mary's Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Charlotte Hall	Charlotte Hall Vet. Home	Prof. Engineer	Fed. Gov't.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	St. Mary	Charlotte Hall	YES ☒ NO ☐	MD Route 5, Charlotte Hall, MD 20622

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	Simon	Sipp	Emma	Caroline	Robinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
Yes -	W.W.I	375-03-5456	Ann S. Ross, Annapolis, Md. 21401

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Met Ca of Prostate.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
John H Weber M.D.	M.D.		2-1-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JOHN H WEBER, M.D.	Calvert Med. Arts & Prof. Bldg Prince Fredrick, Maryland 20678

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY STATE
Cremation	02-03-89	Lee Crematory	Clinton,	P.G., Maryland

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Arehart Funeral Home, Inc., La Plata, Md.	FEB 6 1989	Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other [illegible] event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

023679 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06051 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
GEORGE	RAYMOND	TAYLOR	FEBRUARY 11, 1989	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	BLACK	APRIL 5, 1903	85 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	U.S.A.		ST. MARY'S CO. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LEXINGTON PARK	BAYSIDE NURSING CENTER	LABORER	STATE HIGHWAY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST.MARY'S	LEONARDTOWN	YES ☐ NO ☐	RT. 2, BOX 14/20650

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
GEORGE	WASHINGTON	TAYLOR	MILLIE	E.	GOUGH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		219-16-0504	MARY AGNES STEWART, 6 DOWNS CR. LEONARDTOWN, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/12, 19 79, to 2/11, 19 89, that (I) (we) last saw the deceased alive on 2/9, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D. — 22e. ADDRESS LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-16-89	CHARLES MEMORIAL GARDENS	LEONARDTOWN, ST.MARY'S, MD.

24. FUNERAL DIRECTOR NAME AND ADDRESS: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650

25a. DATE REC'D. BY REGISTRAR: FEB 16 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 3

DHMH-16 25M (VRA 15, 4) 1/79

023005 FEB 89

Items 18a,22a per M.E.Film G650 4/10/89 CG

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06052

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MA 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Eugene	MIDDLE: PRESTON P.	LAST: Thomas	2a. DATE OF DEATH KNOWN [XX] ESTIMATED [ ]	MONTH: 2-	DAY	YEAR: 19 89	2b. HOUR	M
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 5, 1966	6. AGE (IN YEARS LAST BIRTHDAY): 22 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	MONTH: 2-	DAY	YEAR: 19 89
2d. HOUR: 8:10 P M									

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County MD.
10. CITY OR TOWN OF DEATH: Leonardtown	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): St. Mary's Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): MAINTENANCE MAN	12b. KIND OF BUSINESS OR INDUSTRY: GAS STATION

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.	13b. COUNTY: ST.MARY'S	13c. CITY OR TOWN: LEXINGTON PARK	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS: 105 KENT DR./20653

14. FATHER'S NAME FIRST / MIDDLE / LAST: FRANCIS / PAUL / BONDS	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: CATHERINE / C. / THOMAS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES): NO	16b. SOCIAL SECURITY NO.: 220-78-1446	17. INFORMANT ADDRESS: CATHERINE C. BRISCOE	315A GREAT MILLS CT. LEXINGTON PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrhythmia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate couse (a) stoting the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Charles P. Kokes

TITLE (SPECIFY) M.D. MEDICAL EXAMINER: Acting Deputy Chief

DATE SIGNED: 2-5-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-09-89	23c. NAME OF CEMETERY OR CREMATORY: CHARLES MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN / COUNTY / STATE: LEONARDTOWN, ST.MARY'S CO. MD.
24. FUNERAL DIRECTOR NAME AND ADDRESS: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O.BOX 270, LEONARDTOWN, MD. 20650		25a. DATE RECD. BY REGISTRAR: FEB 08 89	25b. REGISTRAR: Gina Davidson-Kendall

07/84 25M BP 347 DHMH - 17 (VR A15 ME (5))

23678 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06053
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
ALICE	ELIZABETH	TIPPETT	2	15	89 / 0100 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	FEB. 3, 1921	68 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD.	U.S.A.		ST. MARY'S CO. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
LOVEVILLE	AT HOME	L.P.N. NURSE ASST.	HOSPITAL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD.	ST. MARY'S	LOVEVILLE	YES ☐ NO ☐	P.O. BOX 111/20656

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
LOUIS	EDWARD	DINGEE	MARY	JOSEPHINE	LONG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		215-34-6039	LINDA M. RICHARDS, P.O. BOX 164, LOVEVILLE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of vulva

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
E. D. Windham	MD	ATTENDING PHYSICIAN ☐	MEDICAL DIRECTOR ☑	STAFF PHYSICIAN ☐	2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
EMILY WINDHAM, M.D.	LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2-17-89	ST. JOSEPH'S CEMETERY	MORGANZA,	ST. MARY'S	MD.

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D BY REGISTRAR
MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O.BOX 270, LEONARDTOWN, MD. 20650	FEB 16 89

BP 10

DHMH - 16 60M 7/84 (VRA 15, 4)

023009 FEB 10 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 06054 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH	DAY	YEAR	2b. HOUR			
ROBERT	JOSEPH	VOLCIAK, SR.	FEB.	9	1989	M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
MALE	WHITE	MAR. 2, 1942	46 YRS.					FEB. 9, 1989	0314 A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH						
PENNSYLVANIA	U.S.A.		ST. MARY'S MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS/INDUSTRY						
LEONARDTOWN	ST. MARY'S HOSPITAL	BUDGET OFFICER	FOREIGN SERVICE						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS					
MARYLAND	ST. MARY'S	MECHANICSVILLE		RT. #1, BOX 330B 20659					
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST				
WALTER		VOLCIAK	MARY		WAGNER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS					
YES	1960-1963	182-32-3239	LOUISE T. VOLCIAK,	RT. #1, BOX 330B MECHANICSVILLE, MD.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ TITLE (SPECIFY) M.D. _____ MEDICAL EXAMINER DATE SIGNED 2/9/89

EXAMINER'S NAME (TYPE OR PRINT) JAMES O. BOYD, M.D. ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	2/13/89	CALVARY ROMAN CATHOLIC	DRUMS, LUZERNE, PENNSYLVANIA
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		FEB 10 '89	Sylvia Davidson

BP 204 1

DHMH - 17
(VR A15 ME (5))
20M 4/82

024883 MAR-3 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06055
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: THEODORE	MIDDLE: WILLIAM	LAST: WHITE	2a. DATE OF DEATH MONTH DAY YEAR: February 22, 1989	2b. HOUR: 8:45 A.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: DEC. 12, 1938	6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: St. Mary's County MD.		
10. CITY OR TOWN OF DEATH: Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ST. MARY'S HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PRINCIPAL CLASSIFIER	12b. KIND OF BUSINESS OR INDUSTRY: CIVIL U.S.GOVT. SERVICE		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST.MARY'S	LEONARDTOWN	YES [ ] NO [ ]	RT. 1, BOX 75I/20650

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
THEODORE	ELI	WHITE	MARGARET	D.	THOMPSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		215-36-3185	MARY RITA WHITE,	SAME AS 13E.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acquired Immune Deficiency Syndrome

DUE TO, OR AS A CONSEQUENCE OF (b): Emultiple complications - Chronic Cryptococcal

DUE TO, OR AS A CONSEQUENCE OF (c): Meningitis, Pneumonia, Zoster, Anemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
[ ]	—	—

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 10/13/88 to 2/22/89, that (I) (we) saw the deceased alive on 2/21/89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
David Allen, M.D.	Leonardtown, Maryland 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-25-89	OUR LADY'S CHURCH CEM.	MEDLEYS NECK, ST.M. MD.

24. FUNERAL DIRECTOR NAME: MATTINGLEY-GARDINER FUNERAL HOME, P.A.
P.O. BOX 270, LEONARDTOWN, MD. 20650

25a. DATE REC'D. BY REGISTRAR: FEB 27 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, page 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 25

DHMH - 1650M 1/81 (VRA 15, 4)

023675 FEB 26 89

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06056
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
LEONA	BELLE	WITHERS	FEBRUARY 16, 1989	3:25 A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	APRIL 2, 1899	89 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
IN.	U.S.A.		ST. MARY'S CO. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
LEXINGTON PARK	BAYSIDE NURSING CENTER	BOOKKEEPING	G.A.O.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	ST.MARY'S	HOLLYWOOD	YES ☐ NO ☐	RT. 3, BOX 739/20636

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ALBERT	WARD	BOALS	MARY	LENORA	PORTERFIELD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
NO		577-40-7391	JOHN W. WITHERS, P.O. BOX 121, HOLLYWOOD, MD. 20636

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Multi Infarct Dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/2 19 83 to 2/16 19 89 that (I) (we) last saw the deceased alive on 2/15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	MD		2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID ALLEN, M.D.	LEONARDTOWN, MD. 20650

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-21-89	MARYLAND VETERANS CEMETERY	CHELTENHAM, P.G. MD.

24. FUNERAL DIRECTOR NAME AND ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	FEB 21 '89	[signature]

BP 6

DHMH-16 25M (VRA 15, 4) 1/79

025343 MAR 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06057
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Flora MIDDLE: (Muirhead) LAST: Zerega	2a. DATE OF DEATH MONTH DAY YEAR: 2-21-89	2b. HOUR: 1:45 P.M.		
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: 2 15 1916	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS / DAYS:	IF UNDER 24 HRS. HOURS / MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ST MARY'S CO. MD.		
10. CITY OR TOWN OF DEATH: LEX. PK.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): BAYSIDE	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	CALVERT	OWINGS	YES ☒ NO ☐	8261 FRANCES LANE 20736

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ARNAUD		Muirhead	SARAH	A	ETHERINGTON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
NO		176-18-4362	SON	RUSSELL A Lummus	8261 FRANCES LN OWINGS, MD 20736

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CA LUNG & METS,	Months.
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6-8-87, 19____, to 2-21-89, 19____, that (I) (we) last saw the deceased alive on 2-16-89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Wm D Boyd III MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/21/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Wm D Boyd III MD	Leonard Town, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	FEB 24, 1989	CEDAR HILL CEMETERY	SUITLAND PRINCE GEORGES MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
FRANCIS J. COLLINS, JR.	500 UNIVERSITY BLVD W SILVER SPRING, MD 20901	FEB 24 '89	Julia Davidson-Randall

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

022093 FEB-9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006058
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Hilda	M.	Boschen	02	02	89 / 7:55A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Nov. 26, 1897	91 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
England	USA	WIDOWED [X]	Somerset MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Crisfield	Alice Byrd Tawes Nursing Home	Supervisor	Publishing Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
~~XXXXXXMD~~	Somerset	Marion	YES [ ] NO [X]	MD Route 667 - RR 1 / 21838

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ernest	H. F.	Norman	Augusta	Abigail	Cross

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	- -	110-07-5454	Ernest Norman - P.O. Box 184A - RD 2	Greenwich, NY 12834

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) HTN CVD — Year

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa: Carcinoma of colon

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/25 19 86 to 2/2 19 89, that (I) (we) last saw the deceased alive on 2/1 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James A. Sterling, MD — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/2/89

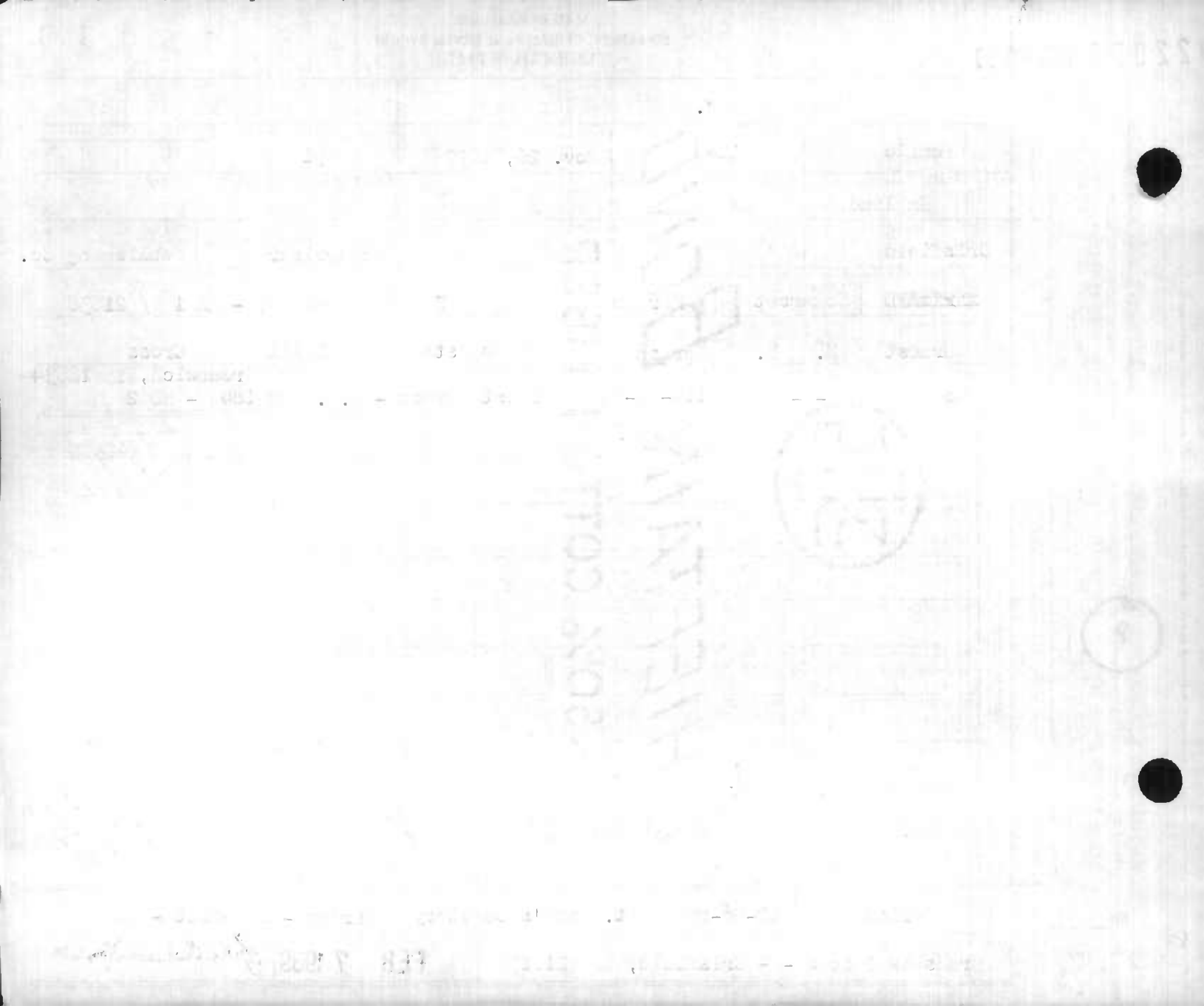
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James A Sterling, MD	320 W. Main St. Crisfield Md. 21817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-06-89	St. Paul's Cemetery	Marion - Somerset - MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradshaw & Sons - - Crisfield, MD 21817	FEB 7 1989	Gisha Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



023509 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06059
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Margaret	Ann	Bromley	Feb. 3, 1989	11:31 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	Nov. 3, 1928	60 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.		Somerset MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Eden	Route 1, Box 297	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Somerset	Eden	YES ☐ NO ☒	Route 1, Box 297, 21822

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Herman	C.	Taylor	Lottie		Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-24-0062	John W. Bromley, Jr.	Rt. 1, Box 297 Eden, Md. 21822

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Breast Cancer	4 years
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 30 May, 19 85, to 3 Feb., 19 89, that (I ~~was~~) last saw the deceased alive on 13 Jan., 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James E. Martin, M.D.	145 E. Carroll Street, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/6/89	Allen	Allen Wicomico Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James L. Williams, Md.	FEB 6 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

1023798 FEB 26 89 FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006060 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MARY	MIDDLE	INEZ	LAST	DAUGHERTY
2a. DATE OF DEATH MONTH DAY YEAR	2 9 89	2b. HOUR	1100 AM		
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	2 24 1892
6. AGE (IN YEARS LAST BIRTHDAY)	96 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Somerset MD.				
10. CITY OR TOWN OF DEATH	CRISFIELD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	GRACE STREET	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	BANK CLERK
12b. KIND OF BUSINESS OR INDUSTRY	BANKING				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	Somerset	CRISFIELD	YES ☐ NO ☒	GRACE STREET CRISFIELD, MD

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	E.	Daugherty	GRACE	STERLING	DAUGHERTY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		214-03-5817	Mr. Billy Jim Tawes Crisfield, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Distress — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Organic Brain Syndrome — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Chronic Urinary Tract Infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital) attended the deceased from 6 - 80 to 2/9 - 89, that (I) (we) last saw the deceased alive on 12-7 - 19 87, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
James A. Sterling	MD		2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James A. Sterling	CRISFIELD, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/11/89	Sunnyridge	CRISFIELD Somerset MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR
Guy C. Sterling	Crisfield, Md.	FEB 10 89	Catherine A. Bradshaw-Anderson

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

0248866 MAR 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06061
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 24a is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Addie MIDDLE: LAST: Harmon
2a. DATE OF DEATH	MONTH DAY YEAR: 2-11-89
2b. HOUR	945 PM
3. SEX	Female
4. RACE	Negro
5. DATE OF BIRTH	MONTH DAY YEAR: 8-22-1910
6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS.
IF UNDER 1 YEAR	MONTHS: DAYS:
IF UNDER 24 HRS.	HOURS: MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Ga.
7b. CITIZEN OF WHAT COUNTRY?	USA
8.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH	Somerset County MD.
10. CITY OR TOWN OF DEATH	Crisfield
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Alice Byrd Tawes MH
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Laborer
12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Worcester
13c. CITY OR TOWN	Pocomoke
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE	21851
14. FATHER'S NAME FIRST MIDDLE LAST	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Easter Little
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)	218 20 3011
17. INFORMANT ADDRESS	Thomas Williams 4490 E. Jewell Ave Denver Colorado

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF (b): Organic Brain Syndrome — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

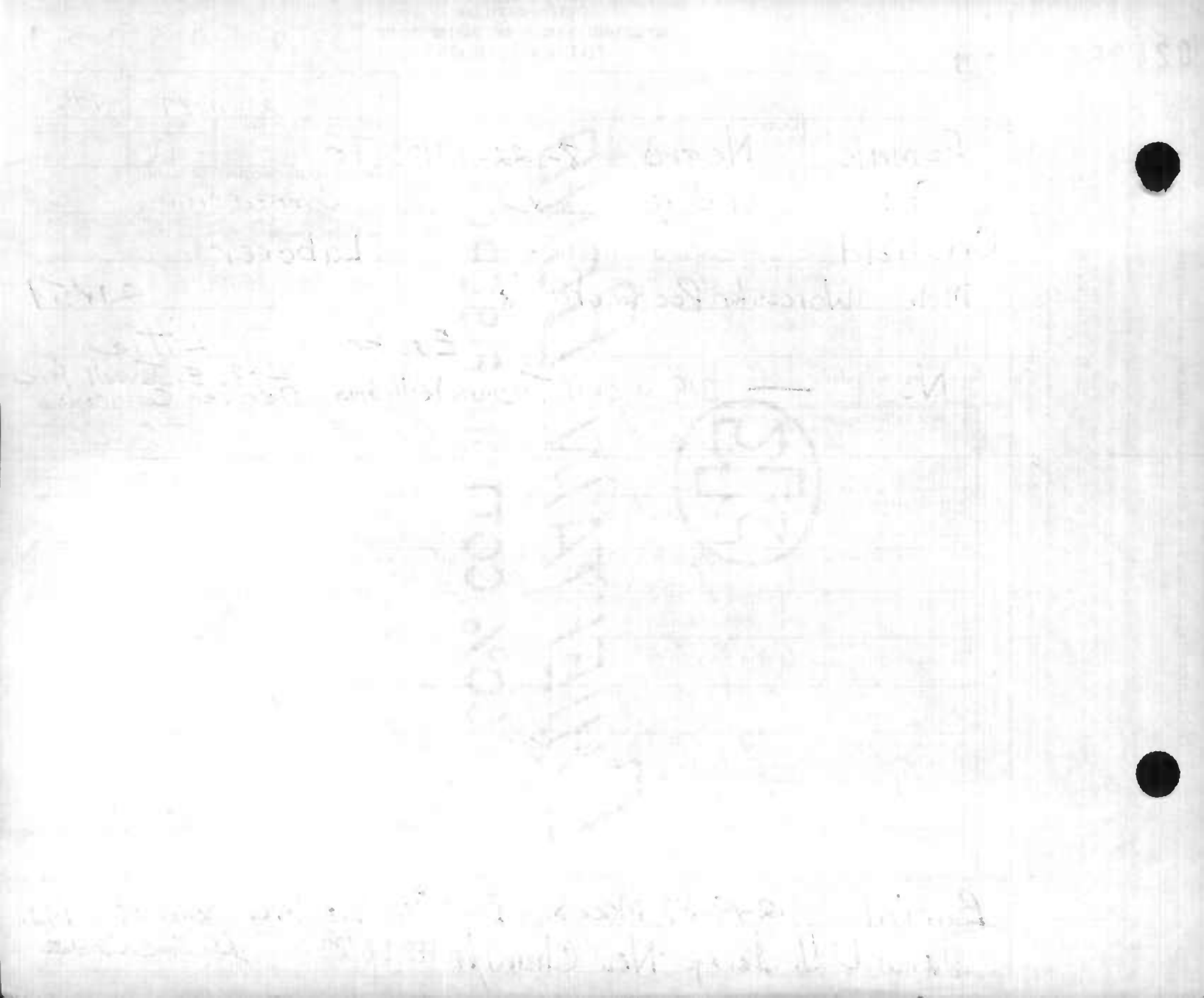
22a. I certify that (I) (this hospital) attended the deceased from 2/6/89 to 3/4/88, 19 to 2/11/89, 19, that (I) (we) last saw the deceased alive on 2/6/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
James A. Bailey, MD		2/12/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	2-19-89	Macedonia Bapt. Cem	Westover Somerset	Md.
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Samuel H. Savage	New Church, Va.	FEB 16 89	Julia Davidson-Randall	

BP 3

DHMH - 16 60M 7/84
(VRA 15, 4)



023797 FEB 25 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89-06062 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the local registrar in obtaining a burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes", Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Emma	MIDDLE: F.	LAST: Hurley	2a. DATE OF DEATH MONTH DAY YEAR: 02 09 89	2b. HOUR: 11:00A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 10 3 1899	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Somerset MD.	
10. CITY OR TOWN OF DEATH: CRISFIELD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Alice Byrd Tawes Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CUTLERY	12b. KIND OF BUSINESS OR INDUSTRY: MANUFACTURING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: Somerset	13c. CITY OR TOWN: CRISFIELD	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 118 Somers Cove Apt 7 21817
14. FATHER'S NAME FIRST: JOSHUA	MIDDLE: T.	LAST: MATTHEWS	15. MOTHER'S MAIDEN NAME FIRST: EVA	MIDDLE: NADDRIX LAST: MATTHEWS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-26-6168	17. INFORMANT: EVA MOORE	ADDRESS: CRISFIELD MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Unknown Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/21 19 87 to 2/9 19 89 that (I) (we) last saw the deceased alive on 2/4 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James A. Sterling, MD DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James A. Sterling 22e. ADDRESS: 320 W Main St. Crisfield Md. 21817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/12/89	23c. NAME OF CEMETERY OR CREMATORY: CRISFIELD Cemetery	23d. LOCATION CITY OR TOWN: CRISFIELD COUNTY: Somerset STATE: MD.	
24. FUNERAL DIRECTOR NAME: Doug C. Sterling ADDRESS: Crisfield, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 10 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 4

DHMH - 16 60M 7/84 (VRA 15, 4)

23470 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006063 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: When the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
CLAUDE	W.	MESSICK	2	16	89 / 11:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	09 23 1909	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Somerset County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Crisfield, Md.	McCready Memorial Hospital	Carpenter	General Const.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Somerset	Crisfield	YES [X] NO [ ]	312 Somers Cove Apts. (21817)

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Claude		Messick	Carrie		Hoffman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	228-14-2637	Edna M. Messick	Same as 13 a,b,c,d,e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Heart MI	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	coronary artery disease	Years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I, this hospital) attended the deceased from 2/12 19 89 to 2/16 19 89 that (I, the) last saw the deceased alive on 2/16 19 89, and that (in my / our) opinion death occurred on the date and hour and from the causes stated above. (I, we) (did / did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
James A. Sterling	MD		2/17/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James A. Sterling, MD	Main St. Crisfield, Md. 21817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02/18/89	Sunnyridge Cemetery	Crisfield Somerset MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradshaws & Sons	Crisfield, MD 21817	FEB 21 1989	Trisha Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

122115 FEB 9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06064
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Maryland law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the time of final disposition. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene to obtain a permit. Then please remove carbonpapers. Pages 1 and 2 should be filed prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Thomas W. Riggin		2a. DATE OF DEATH MONTH DAY YEAR	2-2-89
			2b. HOUR	9:15 a M
3. SEX	Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR	Aug. 18, 1908
6. AGE (IN YEARS LAST BIRTHDAY)	80 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Somerset MD.
10. CITY OR TOWN OF DEATH	Crisfield	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EACH FACILITY GIVE STREET ADDRESS)	Edw.W.McCready Mem. Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Co-owner
12b. KIND OF BUSINESS OR INDUSTRY	Seafood Packers			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Somerset	Crisfield	YES ☐ NO ☒	527 Silver Lane / 21817

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Ralph Riggin	Alma Crockett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW II	218-14-2596	Margaret R. Riggin - same as 13 abcde

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CHF	
DUE TO, OR AS A CONSEQUENCE OF (b)	Malnutrition	
DUE TO, OR AS A CONSEQUENCE OF (c)	Alzheimers Disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Peritoneal Infection, Pancreatitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1.20.89	Jaundice	YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR T9	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 1.15.89, 19____, to ____, 19____, that (I) (we) last saw the deceased alive on 2.2.89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
WGill	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2.3.89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. William Gill	Rt.#413, Crisfield, Md. 21817

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	02-05-89	Sunnyridge Cemetery	Crisfield - Somerset - MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradshaw & Sons, Main St., Crisfield, Md.	FEB 7 1989	Jane Davidson-Randall

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

023556 FEB 22 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06065 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Stout - M.E. notified. to

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dishawn	MIDDLE	LAST: Bailay	2a. DATE OF DEATH MONTH: February DAY: 8 YEAR: 1989	2b. HOUR: 2:45 PM
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: 2 DAY: 8 YEAR: 1986	6. AGE (IN YEARS LAST BIRTHDAY): 3 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.	
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Talbot	13c. CITY OR TOWN: Easton	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: P.O. Box 1365 Easton Md. 21601
14. FATHER'S NAME FIRST: Morris	MIDDLE	LAST: Bailey	15. MOTHER'S MAIDEN NAME FIRST: Patricia	MIDDLE	LAST: Finney
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Patricia Finney	ADDRESS: P.O. 1365 Easton, Md	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure - Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c): Severe Retardation - C.P. Cerebral Palsy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Lung Problems - G.E. Reflux

19a. DATE OF OPERATION: 2/8/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gastrostomy Tube	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Feb 8, 19 86, to Feb 8, 19 89, that (I) (we) last saw the deceased alive on Feb 5, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dana Stout DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-9-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-13-89	23c. NAME OF CEMETERY OR CREMATORY: Mt Zion	23d. LOCATION CITY OR TOWN: Bethlehem / COUNTY: Caroline / STATE: Md.	
24. FUNERAL DIRECTOR NAME: Bennie Smith	ADDRESS: P.O. Box 92 Hurlock, Md	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

25169 MAR 13 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006066
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
William,	O	Binkley	2	24	89	4:32 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
M	CAUC	10	5	25	63 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		TALBOT COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
TRAPPE	Easton Mem. Hosp.	ENGINEER	AEROSPACE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS	21673
MD	TALBOT	TRAPPE		Box 143	

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Owen	Henry	Binkley	Elsie		Downin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
W.W.II	W.W.II	220-18-0533	Doris K. Binkley, P.O.Box 143, Trappe, Md.	21673

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD — yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Patient was shoveling Snow

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/10, 19 87, to 2/24, 19 89, that (I) (we) last saw the deceased alive on 2/7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Hubert L Frey	MD		2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
burial	Feb. 28, 1989	Rest Haven Cemetery	Hagerstown,	Wash.,	Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME	415 E. Wilson Blvd., Hagerstown, Md. 21740	MAR 6 - 1989	Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place the remaining pages, 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75 (VR A 15 (4))

024277 FEB 29 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06067

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Cecile	E.	Blake	February 21, 1989	9:12 AM

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
Female	White	11 20 02	86 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Talbot MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Easton	Meridian - The Pines	Homemaker	--

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Florida		Seminole	YES ☐ NO ☒	10950 Temple Terrace 33542

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Alexander	S.	Butler	Bessie		Willets

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	060-30-1687	Betty Hoffman 1134 Latrobe Dr. 21401

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Suspected Septicemia due to urinary tract infection — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Organic mental syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from 10-15, 19 88, to 2-20, 19 89, that (I) (we) last saw the deceased alive on 2-20, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.

22b. SIGNATURE Lawrence D. Bohan MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 2-21-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
LAWRENCE D. BOHAN	Meridian N.H. Easton, Md.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for the medical examiner's permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	2/22/89	Security Process Crem.	Catonsville Baltimore Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hubbard Funeral Home, Inc.	4107 Wilkens Ave. 21229	FEB 23 1989	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024707 MAR - 6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006068
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Charles	MIDDLE: ALTON	LAST: Blake, JR.	2a. DATE OF DEATH MONTH: February	DAY: 9	YEAR: 1989
			2b. HOUR: 939 pm		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: April DAY: 26 YEAR: 1944	6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Prod. Manager	12b. KIND OF BUSINESS OR INDUSTRY: Manufacturing	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Dorchester	13c. CITY OR TOWN: E. New Market	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: Railroad Avenue/21631

14. FATHER'S NAME FIRST: Charles	MIDDLE: Alton	LAST: Blake, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Margaret	MIDDLE	LAST: Krueger

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): 1964-1968	16b. SOCIAL SECURITY NO.: 214-42-8887	17. INFORMANT ADDRESS: P. O. Box 116 Monika Blake, East New Market, MD 21631

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Glioblastoma Multiforme — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 months
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/1, 19 89, to 2/9, 19 89, that (I) (we) last saw the deceased alive on 2/9, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: Ludwig J. Eglseder III MD	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Ludwig J. Eglseder III MD	22e. ADDRESS: RT 3 Box 106 EASTON md 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-12-89	23c. NAME OF CEMETERY OR CREMATORY: E. New Market Cem.	23d. LOCATION CITY OR TOWN: East New Market, COUNTY: Dor., STATE: MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Zeller Funeral Home, East New Market, MD	25a. DATE REC'D. BY REGISTRAR: MAR 03 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rankin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 76

DHMH - 16 50M 1/81 (VRA 15, 4)

023512 FEB 22 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06069 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Dr. Jensen Notified.

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	John	H	Boston	2a. DATE OF DEATH — MONTH DAY YEAR	February 2 1989
2b. HOUR	8:26A M				
3. SEX	male	4. RACE	Black	5. DATE OF BIRTH — MONTH DAY YEAR	9 6 1922
6. AGE (IN YEARS LAST BIRTHDAY)	66 YRS	IF UNDER 1 YEAR — MONTHS / DAYS	IF UNDER 24 HRS. — HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md.	7b. CITIZEN OF WHAT COUNTRY?	U.S.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Talbot MD.				
10. CITY OR TOWN OF DEATH	Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	laborer
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Caroline	13c. CITY OR TOWN	Denton
13d. INSIDE CITY LIMITS? YES ☑ NO ☐		13e. STREET ADDRESS	801 Riverview Garden		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Ellis		Boston	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Edith Simms
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	215-12-6677
17. INFORMANT	Pearl Boston	ADDRESS			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	—
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary artery disease	10 y
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Recurrent small bowel obstruction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 1/5, 19 89, to 2/2, 19 89, that (I) (~~we~~) last saw the deceased alive on 1/5, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED	2/3/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	ANDREA ALLEN	22e. ADDRESS	POB 122 GOLDSBORO MD 21636

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	2-6-89	23c. NAME OF CEMETERY OR CREMATORY: St. Paul — 23d. LOCATION CITY OR TOWN: Willistor — COUNTY: Caroline — STATE: Md.
24. FUNERAL DIRECTOR NAME	Bennie Smith	ADDRESS	P.O. Box 925 Hurlock, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

025011 MAR 31 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06070
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Jeleta	MIDDLE: S.	LAST: Brink	2a. DATE OF DEATH MONTH DAY YEAR: February 21, 1989
2b. HOUR: 7 12 PM			
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 10, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TEXAS	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	TALBOT	EASTON	YES ☒ NO ☐	501 DUTCHMANS LANE/21601

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
JAMES B. SANDERS	ANNIE WILCOX		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		213-74-8916	CLARK M. BRINK SARATOGA SPRINGS, N.Y

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Mesenteric ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 36°

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ~~Atrial~~ Arterial embolus — 48°

DUE TO, OR AS A CONSEQUENCE OF (c) Atrial fibrillation — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/14/89	acute ischemia of lower extremity	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from Feb 19, 19 89, to Feb 21, 19 89, that (I) (we) last saw the deceased alive on Feb 21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L B Murray — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): L B MURRAY — 22e. ADDRESS: 505 DUTCHMANS LA EASTON

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-23-1989	WOODLAWN MEMORIAL	EASTON, TALBOT, MD.

24. FUNERAL DIRECTOR NAME: Newnam Funeral Home ADDRESS: Easton, Md. 21601

25a. DATE REC'D. BY REGISTRAR: FEB 22 '89

25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

0234511 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 06071

1. DECEASED NAME (TYPE OR PRINT) — FIRST: George — MIDDLE: M. — LAST: Burrier

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH DAY YEAR: 2-1-89 — 2b. HOUR

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH (MONTH DAY YEAR): 12 21 06 — 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YR. (MONTHS, DAYS) — IF UNDER 24 HRS. (HOURS, MIN.)

2c. DATE PRONOUNCED DEAD: 2-1-89 — 2d. HOUR: 2:00 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot County MD.

10. CITY OR TOWN OF DEATH: Easton — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Ingleton on the Miles, 3 mi. W.of — 12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Easton/manager — 12b. KIND OF BUSINESS OR INDUSTRY: Steel co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Talbot — 13c. CITY OR TOWN: Easton — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: Rt 1 Box 189 21601

14. FATHER'S NAME — FIRST: Herbert — MIDDLE — LAST: Burrier

15. MOTHER'S MAIDEN NAME — FIRST: Lillian — MIDDLE — LAST: Marsden

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 278-10-3674

17. INFORMANT — ADDRESS: Jay D Burrier Rt 1 Box 189 Easton MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).: Diabetes Mellitus

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Charles P. Kokes — TITLE (SPECIFY) M.D.: Acting Deputy Chief MEDICAL EXAMINER — DATE SIGNED: 2-2-89

EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes,M.D. — ADDRESS: 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): entombment — 23b. DATE: 2/6/89 — 23c. NAME OF CEMETERY OR CREMATORY: Lorraine Pk Mausoleum — 23d. LOCATION CITY OR TOWN: Baltimore — COUNTY — STATE: Maryland

24. FUNERAL DIRECTOR NAME: Newnam Funeral Home — ADDRESS: Easton, Maryland

25a. DATE REC'D. BY REGISTRAR: FEB 06 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M — BP 12 18 — DHMH - 17 (VR A15 ME (5))

025320 MAR 16 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06072
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Clara	MIDDLE: THOMPSON	LAST: Caulk	2a. DATE OF DEATH MONTH DAY YEAR: 2 25 89	2b. HOUR: 1255 P M	
3. SEX: FEMALE	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: FEB. 20, 1899	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL AT EASTON	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TEACHER PUBLIC	12b. KIND OF BUSINESS OR INDUSTRY: SCHOOL		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	TALBOT	ST. MICHAELS	YES ☒ NO ☐	411 WATER ST. 21663

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
JOHN V. THOMPSON	CLARA SNOW

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	--------	219-36-7364	RACHEL C. GRUENBERG	17 HICKORY DR. MAPLEWOOD N.J. 07040

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/25 19 87 to 2/25 19 89 that (I) (we) last saw the deceased alive on 11/18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
W Bremer MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Wm Bremer	St. Michaels Md 21663

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	MARCH 2, 1989	OLIVET CEMETERY	ST. MICHAELS TALBOT MARYLA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harrison E. Leonard St. Michaels, Md.	FEB 28 '89	Julia Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

025322 MAR 16 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06073 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: CORA B COUNCELL				2a. DATE OF DEATH MONTH DAY YEAR: 02 23 89	2b. HOUR: 0545 AM
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 24, 1903		6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	TALBOT	EASTON	YES ☒ NO ☐	201 FEDERAL ST./ 21601

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
JOHN P. CLAGUE	ALICE TWILLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	**(IF YES, GIVE WAR OR DATES)**	**16b. SOCIAL SECURITY NO.**	**17. INFORMANT ADDRESS**
NO		214-32-1552	ROBERT E. COUNCELL see item 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory failure	Uncertain
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)	Kyphoscoliotic cardiopulmonary disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 02-23 19 72, to 02-23 19 89, that (I) we) last saw the deceased alive on 02-23 19 89, and that in (my) our) opinion death occurred on the date and hour and from the causes stated above (I) we) did) did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert W. Trever, M.D.	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-23-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ROBERT W. TREVER, M.D.	RD 3 Box 297 Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-25-1989	SPRING HILL	EASTON, TALBOT, MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
NEWNAM FUNERAL HOME EASTON, MD.	FEB 27 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

025396 mar 16 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06074

1. DECEASED NAME (TYPE OR PRINT): First: Jeanne | Middle: L | Last: Dautzenberg

2a. DATE OF DEATH: February 28, 1989

2b. HOUR: 1;40a M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: 12 13 09

6. AGE (IN YEARS LAST BIRTHDAY): 79 ~~80~~ YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Holland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.

10. CITY OR TOWN OF DEATH: Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Administrator

12b. KIND OF BUSINESS OR INDUSTRY: Home care

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland | 13b. COUNTY: Talbot | 13c. CITY OR TOWN: Royal Oak | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: Ferry Neck Road 21662

14. FATHER'S NAME: First: Jozef | Middle | Last: Dautzenberg

15. MOTHER'S MAIDEN NAME: First: Johanna | Middle | Last: Krill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no | (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 288-50-1052

17. INFORMANT: Peter Dautzenberg 9184 Remington Dr ADDRESS: Newport Richey FLA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SILENT MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINS

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): MALIGNANT LYMPHOMA

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET | CITY OR TOWN | COUNTY | STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 89 to 2/28 19 89 that (I) (we) last saw the deceased alive on 2/27 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen P. Carney

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-28-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen P. Carney, M.D.

22e. ADDRESS: Rt 3 Box 106 Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 3/4/89

23c. NAME OF CEMETERY OR CREMATORY: Washington Mem. Pk

23d. LOCATION: CITY OR TOWN: Coram | COUNTY: Suffolk | STATE: NY

24. FUNERAL DIRECTOR: NAME: Newnam Funeral Home | ADDRESS: Easton, Maryland

25a. DATE REC'D. BY REGISTRAR: MAR 01 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

023914 FEB 2 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06075 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: Frank Middle: Archie Last: Griffin				2a. DATE OF DEATH Month Day Year: February 5 1989	2b. HOUR: 653 AM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH Month Day Year: June 28, 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot		MD.
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Tool & Die Maker Auto.	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Caroline	Denton	YES ☒ NO ☐	Seventh Street 21629

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Jacob / Archie / Griffin	Carrie / Seman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		186059945	Frank T. Griffin	Newark, Delaware

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 912

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Probable mucous plugging 2° Bronchitis — ~2 hrs

DUE TO, OR AS A CONSEQUENCE OF (c): COPD / Smoking hx — Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hx Ventricular tachycardia / ectopy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
	—	—

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	—	—

22a. I certify that (I) this hospital attended the deceased from Feb 2 19 89, to Feb 5 19 89, that (I) we last saw the deceased alive on Feb 5 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.

22b. SIGNATURE, DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Monica Agree MD	☐ / ☒ / ☐	2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Monica Agree, M.D.	Daffin Lane, Denton, MD 21629

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/8/89	Denton Cemetery	Denton Caroline Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MOORE FUNERAL HOME DENTON	FEB 7 '89	Julia Davidson-Randall

025015 MAR 8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06076
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Virginia	MIDDLE: STEWART	LAST: Harrison	2a. DATE OF DEATH MONTH DAY YEAR: 2-10-89	2b. HOUR: 11:45 PM	
3. SEX: FEMALE	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: SEPT. 30, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: HOME		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: TALBOT	13c. CITY OR TOWN: ST. MICHAELS	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 919 TALBOT ST. 21663	
14. FATHER'S NAME FIRST / MIDDLE / LAST: ALBERT F. STEWART		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: HELEN DENNY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 215-09-6998B	17. INFORMANT: WILSON L. HARRISON	ADDRESS: 919 TALBOT ST. ST. MICHAELS, Md. 21663	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral cerebrovascular accidents — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Month
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: tobacco use

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-11 19 89 to 2-10 19 89, that (I) (we) last saw the deceased alive on 2-10 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Lawrence D Bohan — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): LAWRENCE D. BOHAN M.D.

22e. ADDRESS: DUTCHMANS LANE EASTON, MARYLAND 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 14, 1989	23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL CEMETERY	23d. LOCATION CITY OR TOWN: EASTON / COUNTY: TALBOT / STATE: MARYLAND	
24. FUNERAL DIRECTOR NAME: Harrison & Lemmon	ADDRESS: St. Michaels Md	25a. DATE REC'D. BY REGISTRAR: FEB 15 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21b, marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

25321 MAR 16 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06077
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Beatrice MIDDLE: Marie LAST: Havey			2a. DATE OF DEATH MONTH DAY YEAR: February 24, 1989 — 2b. HOUR: 11:09A M
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: June 20, 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): House wife	12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	talbot	Easton	YES ☒ NO ☐	314 Prospect Ave 21601

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST: Ralph E. Lovett	FIRST MIDDLE LAST: Emily Preece		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 174-14-2347	17. INFORMANT: Lois B. Jackson — ADDRESS: 314 Prospect Ave. Easton, maryland 21601

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction	< 48 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Heart disease	Uncertain
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital) attended the deceased from 01-24, 1985, to 02-24, 1989, that (I) we) last saw the deceased alive on 02-24 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Robert W. Trever, M.D.	☒ ☐ ☐	02-24-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert W. Trever M.D.	RD3 Box 297 Easton, Md 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Feb. 27, 1989	Woodlawn Cemetery	Easton Talbot Maryland

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hansar E. Lenard Ridgely, md.	FEB 28 '89	Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 2

DHMH - 16 50M 1/81
(VRA 15, 4)

22805 FEB 15 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006073

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	PHILIP	JAMES	HOPKINS

2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
	2	1	89	840 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
		MONTH DAY YEAR		MONTHS	DAYS	HOURS	MIN.
Male	White	11 21 1898	90 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		TALBOT MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
EASTON	WILLIAM HILL MANOR	executive	grocery wholesale

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Talbot	Easton	YES X NO ☐	108 Earle Ave. 21601

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	James	Hopkins	Sallie		Wright

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW I	216-03-7525	Gladys C Hopkins	108 Earle Ave Easton MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Refractory Anemia	2 months
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ASHD with Complete Heart Block

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/26/89 19____ to ____ 19____, that (I) (we) last saw the deceased alive on 1/26 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
W Hopkins Wood	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR X STAFF PHYSICIAN ☐	2/1/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William H. Wood, Jr., M.D.	Route 3, Box 106 Easton, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/4/89	Oxford Cemetery	Oxford	Talbot	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home,	Easton, Maryland	FEB 02 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP 15

DHMH - 16 60M 7/84
(VRA 15, 4)

025012 MAR-8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06079
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and given to the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Ruth	MIDDLE: E. VANS	LAST: Hubbard	2a. DATE OF DEATH MONTH DAY YEAR: 2/16/89	2b. HOUR: 5:11 A M
3. SEX: FEMALE	4. RACE: CAUC.	5. DATE OF BIRTH MONTH DAY YEAR: APRIL 25, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PROPRIETOR HUBBARDS APPAREL	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: TALBOT	13c. CITY OR TOWN: ST. MICHAELS	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 404 WATER ST. 21663	
14. FATHER'S NAME FIRST MIDDLE LAST: JOHN S. EVANS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: ELIZABETH SCHILLING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): -------	16b. SOCIAL SECURITY NO.: 214-42-9838	17. INFORMANT: HARRIETT H. HAUGH	ADDRESS: 2427 DELAWARE AVE. WILMINGTON, DEL. 19806		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOVASCULAR ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): SEVERE AORTIC STENOSIS — yrs (Randy)
DUE TO, OR AS A CONSEQUENCE OF (c): RHEUMATIC HEART DISEASE — yrs (Cindy)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Dysrhythmia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12 19 88 to 2/15 19 89, that (I) (we) last saw the deceased alive on 2/15/89 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE AND DEGREE: [signature] MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): KEVIN J. O'KEEFE MD

22e. ADDRESS: PO BOX 106, RODGE 3 EASTON MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 18, 1989	23c. NAME OF CEMETERY OR CREMATORY: OLIVET CEMETERY	23d. LOCATION CITY OR TOWN: ST. MICHAELS, MARYLAND	STATE: talbot
24. FUNERAL DIRECTOR NAME / ADDRESS: Harmon E. Leonard St Michaels, md.		25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

025246 MAR 14

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006080
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Evelyn	MIDDLE	LAST: Johnson	2a. DATE OF DEATH MONTH DAY YEAR: February 17 1989	2b. HOUR: 11:08 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 28, 1897	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.	
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher/Supervisor-Educat.	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Cambridge	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 13 Manito Dr. 21613
14. FATHER'S NAME FIRST MIDDLE LAST: James C. Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Nettie not available		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219-36-6539	17. INFORMANT ADDRESS: Mrs. Martha Jones, Fishing Crk, Md. 21634	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	2 days
DUE TO, OR AS A CONSEQUENCE OF (b)	FX LEFT HIP	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: FEB 11 1989	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): Fell at Home	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): Home	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-11 19 89, to 2-17 19 89, that (I) (we) last saw the deceased alive on 2-17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.

22b. SIGNATURE: Stephen P. Carney, M.D.	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-22-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen P. Carney, M.D.	22e. ADDRESS: Easton, Md. 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-20-89	23c. NAME OF CEMETERY OR CREMATORY: Old Trinity Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Church Creek, Dorc. Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Curran Funeral Home 308 High St. Cambridge Md.	25a. DATE REC'D. BY REGISTRAR: FEB 27 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

24826 MAR -7 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006081

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Thomas G. Jones			2a. DATE OF DEATH MONTH DAY YEAR	2 17 89
				2b. HOUR	5:15 P. M
3. SEX	Male	4. RACE	Cauc.	5. DATE OF BIRTH MONTH DAY YEAR	December 28, 1891
6. AGE (IN YEARS LAST BIRTHDAY)	97 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Talbot MD.				
10. CITY OR TOWN OF DEATH	Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Meridian - The Pines	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Salesman
12b. KIND OF BUSINESS OR INDUSTRY	Eng.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	Neavitt	YES [ ] NO [X]	21652 UNKNOWN

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
George James Jones	Mary Bradley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-----	211-16-8102	Thelma C. Jones	Neavitt, Md. 21652

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOVASCULAR ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF (b) MULTISYSTEM FAILURE — YES
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I **certify** that (I) (this hospital) attended the deceased from 2/17 19 89 to 2/17 19 89, that (I) (we) last saw the deceased alive on 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
KEVIN J. O'KEEFE, M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/17/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	
K O'Keefe MD	Route 3, Box 106, Easton MD 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb 19, 1989	Lee Crematory	Clinton P.G. Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harrison E. Lynch, Pittsville, Md.	FEB 21 89	

BP 17

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06082 REG. NO.

0236 10 FEB

1. DECEASED NAME (TYPE OR PRINT): FIRST LESTER MIDDLE Bryan LAST KINNAMON

2a. DATE OF DEATH: MONTH 02 DAY 3 YEAR 89

2b. HOUR 6 15 P M

3. SEX: MALE

4. RACE: White W

5. DATE OF BIRTH: MONTH 11 DAY 27 YEAR 01

6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? US

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.

10. CITY OR TOWN OF DEATH: EASTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): William Hill MANOR

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrical Engineer

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Talbot

13c. CITY OR TOWN: Easton

13d. INSIDE CITY LIMITS? YES X NO ☐

13e. STREET ADDRESS / ZIP CODE: Dutchman's Lane 21601

14. FATHER'S NAME: FIRST William MIDDLE James LAST Kinnamon

15. MOTHER'S MAIDEN NAME: FIRST Myra MIDDLE LAST Bryan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 233-10-0921

17. INFORMANT: ADDRESS: 1 Chadwick Terr Anna S. Kinnamon Easton, Md. 21601

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from June 80, to Feb 2 19 89, that (I) (we) last saw the deceased alive on Jan 20 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Richard F Kranegal DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/7/89

23c. NAME OF CEMETERY OR CREMATORY: Christ Churchyard

23d. LOCATION: CITY OR TOWN Cambridge COUNTY Dor. STATE Md.

24. FUNERAL DIRECTOR: NAME, ADDRESS: THOMAS FUNERAL HOME CAMBRIDGE, MD.

25a. DATE REC'D. BY REGISTRAR: FEB - 9 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

P

BP 12

DHMH - 16 60M 7/84 (VRA 15, 4)

025331 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060833 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Thomas Middle: ALBERT Last: Mowbray				2a. DATE OF DEATH Month Day Year: 2/20/89	2b. HOUR: 9:05AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH Month Day Year: FEBRUARY 24, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Meridian - The Pines	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): KITCHEN HELPER	12b. KIND OF BUSINESS OR INDUSTRY: HEALTH CARE		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	DORCHESTER	EAST NEW MKT	YES ☐ NO ☒	MD ROUTE 14/21631

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
DANIEL / JAMES / MOWBRAY	NELLIE / MAE / DUNN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	-	218-01-6947	MINNIE MOWBRAY, EAST NEW MARKET, MD 21631

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	C&D. Lobular Pneumonia	48 hrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	CLL (suspect viral)	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): recent aspiration pneumonia — ASCVD —

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
—	—	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/6 19 78, to 2/20 19 89, that (I) (we) last saw the deceased alive on 2/20 19 89 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

22b. SIGNATURE: Albert T. Dawkins Sr. DEGREE: M ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ALBERT T. DAWKINS SR 22e. ADDRESS: 508 IDLEWILD AV. EASTON, MARYLAND 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-22-89	EAST NEW MARKET CEM.	EAST NEW MARKET, DORCHESTER, MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631	MAR - 3 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024850 MAR -8

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 8 9 0 6 0 3 4

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ASBURY — MIDDLE: — LAST: NICHOLSON

2a. DATE OF DEATH — MONTH: 2 — DAY: 26 — YEAR: 89

2b. HOUR: 130 P M

3. SEX: M

4. RACE: B

5. DATE OF BIRTH — MONTH: 10 — DAY: 8 — YEAR: 02

6. AGE (IN YEARS LAST BIRTHDAY): ~~87~~ 86 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT — MD.

10. CITY OR TOWN OF DEATH: EASTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: QA.

13c. CITY OR TOWN: Stevensville

13d. INSIDE CITY LIMITS? YES ☐ NO ☑

13e. STREET ADDRESS: Cox Road 21638

14. FATHER'S NAME — FIRST: OSCAR — MIDDLE: — LAST: Nicholson

15. MOTHER'S MAIDEN NAME — FIRST: — MIDDLE: Wickerson — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 217 36 0359

17. INFORMANT — ADDRESS: Ray F Nicholson Chester Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: day
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/21, 19 89, to 2/26, 19 89, that (I) (we) last saw the deceased alive on 2/26, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gregg Rhodes — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Peter Gregg Rhodes MD

22e. ADDRESS: 503 Dutchman's Lane, Easton, Md 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): B

23b. DATE: 3/3/89

23c. NAME OF CEMETERY OR CREMATORY: Bath's Neck

23d. LOCATION — CITY OR TOWN: Stevensville — COUNTY: QA — STATE: Md.

24. FUNERAL DIRECTOR — NAME: ERRIC DASHIELDS — ADDRESS: F/H Easton

25a. DATE REC'D. BY REGISTRAR: MAR 02 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

025323 MAR 16 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006085
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	HARRY A. OFFUTT	2a. DATE OF DEATH MONTH DAY YEAR	FEB. 22, 1989
2b. HOUR	7 P. M		
3. SEX	MALE	4. RACE	CAUCASIAN
5. DATE OF BIRTH MONTH DAY YEAR	OCT. 21, 1903	6. AGE (IN YEARS LAST BIRTHDAY)	85 YRS
IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PENNA.	7b. CITIZEN OF WHAT COUNTRY?	U.S.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	TALBOT MD.
10. CITY OR TOWN OF DEATH	EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	R.D. #4, BOX 379
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	golf prof.	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	TALBOT
13c. CITY OR TOWN	EASTON	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	R.D. #4, BOX 379 /21601		
14. FATHER'S NAME FIRST MIDDLE LAST	WILLIAM J. OFFUTT	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	MAUDE RUMBAUGH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	YES.	(IF YES, GIVE WAR OR DATES)	W.W. II
16b. SOCIAL SECURITY NO.	088-07-7129	17. INFORMANT ADDRESS	JANE S. OFFUTT see item 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Malignant Melanoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/21/89 to 2/22/89, that (I) (we) last saw the deceased alive on 2/21/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Wm H Wood	DEGREE	MD
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐		22c. DATE SIGNED	2/23/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Wm H Wood	22e. ADDRESS	EASTON MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	CREMATION	23b. DATE	2-23-89	
23c. NAME OF CEMETERY OR CREMATORY	EASTERN SHORE	23d. LOCATION CITY OR TOWN COUNTY STATE	GEORGETOWN SUSSEX, DEL.	
24. FUNERAL DIRECTOR NAME ADDRESS	NEWNAM FUNERAL HOME EASTON, MD. 21601	25a. DATE REC'D. BY REGISTRAR	FEB 27 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

024894 MAR -8 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06086
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Peter	MIDDLE: O	LAST: O'Neal	2a. DATE OF DEATH MONTH: 2 DAY: 18 YEAR: 89	2b. HOUR: 9:15 P M
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MONTH: Sept DAY: 25 YEAR: 1913	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MNC - The Pines	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Dorchester	Cambridge	YES ☐ NO ☐	606 North Dr. / 21613

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Peter O O'Neal	Annie O'Neal		244-05-8586	Gloria Holland 606 North Dr. Camb. Md 21613

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Mins.
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebral Vascular dz — 4 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Old CVA Seizure disorder - Severe peripheral Vascular Dz

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
/		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from Jan 11, 1988, to Feb 18, 1989, that (I) (we) last saw the deceased alive on Feb 15, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/25/89	Bethel Cem	Cambridge Dor. Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Stewart Funeral Home Cambridge Md.

25a. DATE REC'D. BY REGISTRAR: FEB 22 '89

25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

BP

DHMH - 1650M 1/81 (VRA 15, 4)

024815 MAR - 7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06087
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. Medical examiner must be notified of cases IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: William MIDDLE: H. LAST: Parsons, Sr.			2a. DATE OF DEATH MONTH: 2 DAY: 8 YEAR: 89	2b. HOUR: 332 A M
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: Aug. DAY: 3 YEAR: 1914	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.	
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner	12b. KIND OF BUSINESS OR INDUSTRY: Roofing co.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Caroline	Denton	YES ☒ NO ☐	111 Franklin Street 21629

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Charles / Ervin / Parsons	Nellie / Louise / Hobbs	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212264230	17. INFORMANT ADDRESS: William H. Parsons, Jr. Baltimore, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Abd. Aortic Aneurysm — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: P minutes
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from July 29 19 87, to April 18 19 88, that (I) (we) last saw the deceased alive on April 18 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Monica Agree	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/8/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Monica Agree, M.D.		22e. ADDRESS: Daffin Lane, Denton, Maryland 21629	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/10/89	Denton Cemetery	Denton CAroline MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Moore Funeral Home Denton, Md.	FEB 16 89	Jicka Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 060883

023600 FEB 23 89

1. DECEASED NAME (TYPED OR PRINT) — FIRST: George; MIDDLE: L.; LAST: Prescott
2a. DATE OF DEATH — MONTH DAY YEAR: February 5, 1989
2b. HOUR: 1050 M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: Oct. 25, 1902
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maine
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.
10. CITY OR TOWN OF DEATH: Easton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer
12b. KIND OF BUSINESS OR INDUSTRY: Farm

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Caroline
13c. CITY OR TOWN: Greensboro
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: Maple Village 21639

14. FATHER'S NAME — FIRST: Charles; MIDDLE: L.; LAST: Prescott
15. MOTHER'S MAIDEN NAME — FIRST: Iona; MIDDLE: E.; LAST: Heath
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16a. (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 005-03-4347
17. INFORMANT — ADDRESS: Dorothy Prescott Greensboro, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA & SEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): PARKINSONS DISEASE — 4 YRS
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-5, 19 89, to 2-5, 19 89, that (I) (we) last saw the deceased alive on 2/5, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/6/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT):
22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-10-89
23c. NAME OF CEMETERY OR CREMATORY: New Sharon Cemetery
23d. LOCATION — CITY OR TOWN: New Sharon COUNTY: Franklin STATE: ME

24. FUNERAL DIRECTOR — NAME AND ADDRESS: Fleegle-Helfenbein Funeral Home, Greensboro, MD
25a. DATE REC'D. BY REGISTRAR: FEB 15 1989
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

0 2 5 0 1 8 MAR - 8 10

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 9 0 6 0 8 9
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and given to the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert	MIDDLE: R	LAST: Price	2a. DATE OF DEATH MONTH: 2	DAY: 11	YEAR: 89
2b. HOUR					
3. SEX: Male	4. RACE: BLK	5. DATE OF BIRTH MONTH: 4	DAY: 20	YEAR: 14	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 506 Glenwood Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer.	12b. KIND OF BUSINESS OR INDUSTRY: Const.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Md	13b. COUNTY: Talbot	13c. CITY OR TOWN: Easton	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 506 Glenwood Ave 21601	
14. FATHER'S NAME FIRST: Covant	MIDDLE: W	LAST: Price	15. MOTHER'S MAIDEN NAME FIRST: Maggie	MIDDLE	LAST: Morris
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.	17. INFORMANT: George	ADDRESS: Price	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma Stomach — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 2/26/85, 19___, to 2/11/89, 19___, that (I) (we) last saw the deceased alive on 2/10/89, 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C. M. Bain	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/16/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): C. Bain	22e. ADDRESS: 415 E. Dover, Easton, Md, 21601		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 2/18/89	23c. NAME OF CEMETERY OR CREMATORY: Sandtown	23d. LOCATION CITY OR TOWN: Hillsboro	COUNTY: QA STATE: MD
24. FUNERAL DIRECTOR: George [illegible]	ADDRESS: Easton Md	25a. DATE REC'D BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

024262 FEB 2 0 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006090

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for local transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes" for item 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	GEORGE E. QUIRI			2a. DATE OF DEATH MONTH DAY YEAR	February 10, 1989
2b. HOUR	8:48 M				
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	10 18 02
6. AGE (IN YEARS LAST BIRTHDAY)	86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	New York	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Talbot MD.				
10. CITY OR TOWN OF DEATH	Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	102 Hughlett Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	owner/dealer
12b. KIND OF BUSINESS OR INDUSTRY	cattle/horse farm				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	Easton	YES ☒ NO ☐	102 Hughlett Avenue 21601

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Alfred Quiri	Mary Young

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		128-30-1014	Ruth Quiri	102 Hughlett Ave Easton MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of intestine — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 72 to 2/10 19 89 that (I (we) last saw the deceased alive on 2/9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
P. Gregg Rhodes	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/14/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	P. Gregg Rhodes, M.D.	22e. ADDRESS	503 Dutchman's Lane Easton, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial		Fairview Cemetery	Amsterdam Montgomery NY

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home, Easton, Maryland	FEB 14 '89	Julia Gardner-Randall

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

23448 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06091

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2. DECEASED NAME (TYPE OR PRINT) FIRST: EMMA	MIDDLE: A.	LAST: SCHMIDT	2a. DATE OF DEATH MONTH DAY YEAR: 2-6-89	2b. HOUR: 905 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 12, 1897	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ft. Smith, Ark.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Nurse's Aid	12b. KIND OF BUSINESS OR INDUSTRY: Hospital		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Caroline	13c. CITY OR TOWN: Preston	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt. 2, Box 65	21655
14. FATHER'S NAME FIRST MIDDLE LAST: Christian Schmidt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Louise Werfelman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-28-8092	17. INFORMANT: Homer O. Schmidt, Rt. 1, Box 82, Md.	ADDRESS: Preston 21655	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF
(b): ASCVD — years
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-6-85 to 2-6-89, that (I) (we) last saw the deceased alive on 2-6-89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE: William J. Bagwell	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-6-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb. 9, 1989	23c. NAME OF CEMETERY OR CREMATORY: Junior Order Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Preston, Caroline, Md.	
24. FUNERAL DIRECTOR NAME: Framptom-Hawkins F.H.	ADDRESS: Federalsburg 216 N. Main St.	25a. DATE REC'D BY REGISTRAR: FEB 09 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 23

DHMH - 1650M 1/81 (VRA 15, 4)

025324 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

39 06092 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MARIA; MIDDLE: G.; LAST: SERRANO			2a. DATE OF DEATH — MONTH DAY YEAR: February 23, 1989	2b. HOUR: 9:37 AM
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH — MONTH DAY YEAR: JAN. 1, 1897	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ITALY	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: TALBOT	13c. CITY OR TOWN: EASTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 401 TRIPPE AVE./21601
14. FATHER'S NAME — FIRST MIDDLE LAST: PIETRO GERACE			15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: CONCETTA DeMAIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 220-05-7716	17. INFORMANT — ADDRESS: MARY S. MASON — see item 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEART FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): AORTIC STENOSIS / ATRIAL FIBRILLATION
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COMPRESSION FRACTURE LUMBAR VERTEBRA.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/13/89, 19__, to 2/23/89, 19__, that (I) (we) last saw the deceased alive on 2/23/89 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

22b. SIGNATURE: C.W. Bain	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/23/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): C.R.W. BAIN	22e. ADDRESS: DOVER STREET, EASTON, MD. 21601		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-28-1989	23c. NAME OF CEMETERY OR CREMATORY: SPRING HILL	23d. LOCATION — CITY OR TOWN COUNTY STATE: EASTON, TALBOT, MD.	
24. FUNERAL DIRECTOR — NAME: NEWNAM FUNERAL HOME	ADDRESS: EASTON, MD.	25a. DATE REC'D. BY REGISTRAR: FEB 27 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 1

DHMH - 16 50M 1/81 (VRA 15, 4)

025272 MAR M 18

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060 93
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Finley	Middle: Ross	Last: Sparks, Jr.	2a. DATE OF DEATH Month Day Year: February 22, 1989	2b. HOUR: 1:30 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: May 27, 1926	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.	
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PoliceOfficer(Ret)	12b. KIND OF BUSINESS OR INDUSTRY: State of Maryland	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	QueenAnne's	Grasonville	YES ☐ NO ☒	P.O. Box 276 21638

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Finley	Ross	Sparks	Delma	Elizabeth	Dawkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	221-18-9656	Wife	P.O. Box 276 Shirley M. Sparks, Grasonville, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac failure	38
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Acute occlusion @ circumflex	
DUE TO, OR AS A CONSEQUENCE OF (c)	Severe 3 vessel ASCHD	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Old anteroseptal MI

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Reinhardt Sahmel	MD	☐ / ☐ / ☒	2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Reinhardt Sahmel MD	LAB Memorial Hospital Easton

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 25, 1989	ChesterfieldCemetery	Centreville, QueenAnne's, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James H. Barton, Jr.,	Barton Funeral Home Centreville, Md. 21617	FEB 27 '89	Julia Davidson-Randall

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

024260 FEB 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060941 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in obtaining burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 31

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harriet	MIDDLE: D.	LAST: Spring	2a. DATE OF DEATH MONTH DAY YEAR: 2-10-89	2b. HOUR: 11:55 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 05 19 1895	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): William Hill Manor	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Talbot	Easton	YES ☒ NO ☐	501 Dutchman's Lane 21601

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Solomon	LeFevre	Devo	Harriet		Brandon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		216-46-1497	Rodney Spring Rt 5 Box 754 Easton MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	Min-sec
DUE TO, OR AS A CONSEQUENCE OF (b)	(R) LL Pneumonia	days
DUE TO, OR AS A CONSEQUENCE OF (c)	dehydration	days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ASCVD, depression, ↓

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from April 26, 19 88, to Feb 10, 19 89, that (I) (we) last saw the deceased alive on feb 7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Ann H. Webb, M.D.	607 Dutchmans Lane Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/14/89	Oxford Cemetery	Oxford	Talbot	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home	Easton, Maryland	FEB 14 '89	Julia Davidson-Randall

024825 MAR - 7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06095
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BPL

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JAMES BAUER Spurry	2a. DATE OF DEATH MONTH / DAY / YEAR	2 - 18 - 89	2b. HOUR	12:26 PM
3. SEX	MALE	4. RACE	CAUC.	5. DATE OF BIRTH MONTH / DAY / YEAR	APR 28, 1924
6. AGE (IN YEARS LAST BIRTHDAY)	64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	
9. BALTIMORE CITY OR COUNTY OF DEATH	TALBOT MD.				
10. CITY OR TOWN OF DEATH	EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	HUNTING & FISHING GUIDE
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	TALBOT	13c. CITY OR TOWN	St. MICHAELS
13d. INSIDE CITY LIMITS?	YES ☐ NO ☒	13e. STREET ADDRESS	21663		UNKNOWN
14. FATHER'S NAME FIRST / MIDDLE / LAST	FRANK H. SPURRY	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	FRANCES AMERKUS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	YES	(IF YES, GIVE WAR OR DATES)	WW II	16b. SOCIAL SECURITY NO.	217-12-4329
17. INFORMANT	KITTY S. MILLER	ADDRESS	CALVERT ST., ST. MICHAELS, MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SMALL CELL LUNG CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mo
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-16 19 89 to 2-18 19 89, that (I) (we) last saw the deceased alive on 2-17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Stephen Carney	DEGREE: ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/21/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	STEPHEN CARNEY MD	22e. ADDRESS	DUTCHMAN'S LANE EASTON

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	BURIAL	23b. DATE	FEB 20, 1989	23c. NAME OF CEMETERY OR CREMATORY: OLIVET CEM.
23d. LOCATION CITY OR TOWN / COUNTY / STATE	ST MICHAELS TALBOT MD			
24. FUNERAL DIRECTOR NAME / ADDRESS	Harrison & Leonard, St. Michaels, Md	25a. DATE RCD. BY REGISTRAR	2 21 89	25b. REGISTRAR'S SIGNATURE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 06096

1234447 FEB 22 89

1. DECEASED NAME (TYPE OR PRINT): First Helen Middle M. PARKER Last Stanley
2a. DATE OF DEATH: Month 1 Day 30 Year 89
2b. HOUR: 12:17 AM
3. SEX: Female
4. RACE: Black
5. DATE OF BIRTH: Month April Day 5 Year 1915
6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. If under 1 year: Months / Days; If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Hurlock, Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.
10. CITY OR TOWN OF DEATH: EASTON
11. NAME OF HOSPITAL, ~~NURSING HOME OR OTHER INSTITUTION~~ (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Food Processor
12b. KIND OF BUSINESS OR INDUSTRY: Con Agra

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Dorchester
13c. CITY OR TOWN: Hurlock
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: Rt. 1, Box 160B 21613

14. FATHER'S NAME: First John Middle F. Last Butler
15. MOTHER'S MAIDEN NAME: First Lola Middle M. Last Adams
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 219-01-9433
17. INFORMANT: Rev. Luther R. Stanley, Rt. 1, Box ADDRESS 160B, Hurlock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — Approximate interval between onset and death: Immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ~~HEART~~ myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c): (presumed)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Metastatic carcinoma of colon

19a. DATE OF OPERATION: 1/24/89
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: colon carcinoma
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/23/89 19__ to 1/30/89 19__, that (I) (we) last saw the deceased alive on 1/29/89 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.
22b. SIGNATURE: L B Murray — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 1/30/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LATHAM B MURRAY
22e. ADDRESS: 505 DUTCHMAN'S LA EASTON MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Feb. 4, 1989
23c. NAME OF CEMETERY OR CREMATORY: Petersburg Cem.
23d. LOCATION: CITY OR TOWN Hurlock, COUNTY Dorchester, STATE Md.

24. FUNERAL DIRECTOR: NAME Frampton Hawkins ADDRESS Federalsburg, Md.
25a. DATE REC'D. BY REGISTRAR: FEB 03 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or not.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

025014 MAR 0 6 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06097
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 7

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Elsie	MIDDLE: May	LAST: Stevens	2a. DATE OF DEATH MONTH DAY YEAR: 02 21 89	2b. HOUR: 5P M	
3. SEX: FEMALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR: JAN. 16, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.		
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MERIDIAN NURSING CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	TALBOT	ROYAL OAK	YES ☒ NO ☐	RT. #329 / 21662

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
GEORGE I. JUMP	BESSIE MAY COULBOURNE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		220-01-9385	GEORGE A. FINK, JR.	ROYAL OAK, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF: (b) Urinary Tract Infection
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF: (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Cerebrovascular Accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (the physicians attended the deceased from Dec 19 20 to 21 Feb 19 89 that (I) (~~was~~ last saw the deceased alive on 19 Feb 89 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: R. Lane Wroth, MD DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-23-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): R. LANE WROTH, M.D. 22e. ADDRESS: ST. MICHAELS, MD. 21663

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-25-1989	SPRING HILL	EASTON, TALBOT, MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
NEWNAM FUNERAL HOME EASTON, MD.	FEB 22 '89	Julia Davidson-Rondelle

024824 MAR - 7 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060938 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The physician should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows an injury, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MARIAN; MIDDLE: L.; LAST: TARR			2a. DATE OF DEATH — MONTH: 2; DAY: 9; YEAR: 89	2b. HOUR: 11 59 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH — MONTH: 12; DAY: 04; YEAR: 18	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: TALBOT MD.	
10. CITY OR TOWN OF DEATH: EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): homemaker	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Talbot	St Michaels	YES ☒ NO ☐	Willow Street 21663

14. FATHER'S NAME — FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME — FIRST	MIDDLE	LAST
Calvin	Montgomery	Hunt	Anita		Louis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		157-16-2564	George R Tarr Sr.	P O Box 383 St Michaels MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): COLON CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 mo
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 2 Nov 88, to 2/9 89, that (I) (we) last saw the deceased alive on 2/9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Stephen P. Carney	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-10-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Stephen P. Carney, M.D.	Rt 3 Box 106 Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN, COUNTY, STATE
Burial	2/13/89	Olivet Cemetery	St Michaels Talbot MD

24. FUNERAL DIRECTOR — NAME, ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newnam Funeral Home Easton, Maryland	FEB 13 '89	[signature]

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

025017 MAR-8 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 060997 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	EDWARD T. TRAVERS, SR.
2a. DATE OF DEATH — MONTH DAY YEAR	2-17-89
2b. HOUR	810 AM
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH — MONTH DAY YEAR	Feb. 8, 1915
6. AGE (IN YEARS LAST BIRTHDAY)	74 YRS
IF UNDER 1 YEAR — MONTHS / DAYS	
IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Crapo, Md.
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	TALBOT MD.
10. CITY OR TOWN OF DEATH	EASTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Farmer
12b. KIND OF BUSINESS OR INDUSTRY	Farming
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland
13b. COUNTY	Caroline
13c. CITY OR TOWN	Federalsburg
13d. INSIDE CITY LIMITS? YES [X] NO [ ]	
13e. STREET ADDRESS	205 Park Avenue 21632
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Matthew Thomas Travers
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Mahalie Elizabeth Lewis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	214-07-8764
17. INFORMANT — ADDRESS	Beulah Travers, 205 Park Ave., Md. Federalsburg,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma left lower lung mid

DUE TO, OR AS A CONSEQUENCE OF (c) widespread bone mets

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: COPD

19a. DATE OF OPERATION	none
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	—
20a. AUTOPSY? YES [ ] NO [X]	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]	
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR	— 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	—
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 89, to 2/17 19 89, that (I) (we) last saw the deceased alive on 2/17 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	Albert Dawkins
DEGREE	MD
ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	
22c. DATE SIGNED	2/17/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	ALBERT T. DAWKINS JR
22e. ADDRESS	208 IDLEWILD AVE EASTON MARYLAND 21601
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial
23b. DATE	Feb. 20, 1989
23c. NAME OF CEMETERY OR CREMATORY	E. New Market Cem.
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	E. New Market, Dor., Md.
24. FUNERAL DIRECTOR — NAME / ADDRESS	Framptom-Hawkins F.H., 216 N. Main St. Federalsburg
25a. DATE REC'D. BY REGISTRAR	FEB 21 '89
25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

0 2 3 4 9 FEB 22 '89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06100

1. DECEASED NAME (TYPE OR PRINT): FIRST Frances MIDDLE M. LAST Watson

2a. DATE OF DEATH: MONTH February DAY 1 YEAR 1989

2b. HOUR 2.09 PM

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH: MONTH March DAY 14 YEAR 1919

6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.

10. CITY OR TOWN OF DEATH: Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Dorchester

13c. CITY OR TOWN: Hurlock

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Rt. 2, Box 115A 21643

14. FATHER'S NAME: FIRST Carroll MIDDLE LAST Watson

15. MOTHER'S MAIDEN NAME: FIRST Mazzie MIDDLE LAST Waters

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16a. (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 216-10-9496

17. INFORMANT: ADDRESS: Hurlock, Md. Charlotte Nichols, Rt. 2, Box 615,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Peritonitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Diverticulitis

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c).

19a. DATE OF OPERATION: 1/27/89

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Diverticulitis

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/23/89 19____ to 2/1/89 19____ that (I) (we) last saw the deceased alive on 2/1/89 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): L. Thomas Divilio, M.D.

22e. ADDRESS: 404 Marvel Ct Easton, MD 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb. 6, 1989

23c. NAME OF CEMETERY OR CREMATORY: Petersburg Cem.

23d. LOCATION: CITY OR TOWN Hurlock COUNTY Dor. STATE Maryland

24. FUNERAL DIRECTOR: NAME Frampton Hawkins ADDRESS Federalsburg, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 09 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

1237.7 FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06101

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on page 3 it shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: MARTHA	Middle: Ellen	Last: Williamson	2a. DATE OF DEATH Month Day Year: 2-7-89	2b. HOUR: 6:00 A.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month Day Year: Jan. 14 1923	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Talbot MD.		
10. CITY OR TOWN OF DEATH: Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Caroline	Federalsburg	YES ☒ NO ☐	Rt. 2 21632

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Elmer Lee Tyndall	Mamie Addie Bratton	No / -----	218-24-2657	Clara E. Hudson Box 84 Rt. 1 Parsonsburg, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Severe Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19 89, that (I) (we) last saw the deceased alive on 2/6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Peter R Rhodes MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
PGreg Rhodes MD	503 Dutchman's Lane, Easton, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-9-1989	Jerusalem Cemetery	Parsonsburg Wicomico MD

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bounds FUNERAL HOME	SALISBURY, MARYLAND	FEB 10 '89	Julia Davidson Randall

BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

024564 MAR 1 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06102

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Ricky — MIDDLE: Junior — LAST: Albaugh			2a. DATE OF DEATH — MONTH: 2 — DAY: 20 — YEAR: 89
2b. HOUR: 11.56am			
3. SEX: male	4. RACE: white	5. DATE OF BIRTH — MONTH DAY YEAR: Dec. 12, 1957	6. AGE (IN YEARS LAST BIRTHDAY): 31 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): - - -	12b. KIND OF BUSINESS OR INDUSTRY: - - -
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: West Va.	13b. COUNTY: Berkeley	13c. CITY OR TOWN: Falling Waters	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Route 1, Box 256-A 99999			
14. FATHER'S NAME — FIRST: Ritchie — MIDDLE — LAST: Albaugh		15. MOTHER'S MAIDEN NAME — FIRST: Opal — MIDDLE — LAST: Nida	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-32-1357	17. INFORMANT — ADDRESS: Ritchie Albaugh, Fallings Waters, W.VA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septic Shock.
DUE TO, OR AS A CONSEQUENCE OF (b): Hepatic Failure / Hepato-Renal Syndrome
DUE TO, OR AS A CONSEQUENCE OF (c): Alcoholic Cirrhosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION: N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N A	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-19 19 89, to 2-20 19 89, that (I) (we) last saw the deceased alive on 2-19-89 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): SHAFI.	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: Feb. 22, 1989	23c. NAME OF CEMETERY OR CREMATORY: Harmony Cemetery	23d. LOCATION — CITY OR TOWN / COUNTY / STATE: Falling Waters, Berk., W.Va.
24. FUNERAL DIRECTOR — NAME / ADDRESS: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

BP

99999

DHMH - 16 50M 1/81 (VRA 15, 4)

023640 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06103
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: LOUISE	LAST: ALLEN	2a. DATE OF DEATH MONTH DAY YEAR: February 6, 1989	2b. HOUR: 9:25 AM	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 10 - 21 - 06	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Avalon Manor	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): lathe operator	12b. KIND OF BUSINESS OR INDUSTRY: machine		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 804 Oak Hill Avenue 21740	
14. FATHER'S NAME FIRST: Lee	MIDDLE: B.	LAST: Gruber, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: Ann	LAST: Kreps
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-09-3049	17. INFORMANT: Lee B. Gruber, Jr., Charlestown, W. Va.	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Rectal Carcinoma with metastases

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerosis, dementia, diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from March 31 19 81 to February 6 19 89, that (I) (we) last saw the deceased alive on February 6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Allen W Doll MD

22e. ADDRESS: 1610 Oak Hill Ave Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: Feb. 9, 1989	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE RECD. BY REGISTRAR: FEB 8 89	25b. REGISTRAR'S SIGNATURE: [signature]	

124563 MAR -3 91 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 9 0 6 1 0 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Edna	MIDDLE: Mae	LAST: Baker	2a. DATE OF DEATH MONTH: 02 DAY: 25 YEAR: 89	2b. HOUR: 0615 PM	
3. SEX: F	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 23, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 71 '70 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	1157 Corbett Street 21740

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Samuel / E. / Fitz	Elsie / M. / Fissel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-10-3128	17. INFORMANT ADDRESS: George A. Fitz, Williamsport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic disease. — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Viral pneumonitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to present, 19____, that (I) (we) last saw the deceased alive on 24 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/28/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 28, 1989	Rest Haven Cem.	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 28 '89	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

024562 MAR 5-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06105

1. DECEASED NAME (TYPE OR PRINT) FIRST: Gladys	MIDDLE: Amelia A.	LAST: BILLMAN	2a. DATE OF DEATH MONTH: 2 DAY: 21 YEAR: 89	2b. HOUR: 2010 M	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 2, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
				IF UNDER 24 HRS HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): kitchen	12b. KIND OF BUSINESS OR INDUSTRY: restaurant	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	453 Antietam Dr. 21740

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Samuel / / Snyder	Mabel / M. / Staubs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no			Freda Harbaugh, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Cardiomyopathy — years

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic heart disease — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumococcal septicemia, non-hodgkin's lymphoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (~~the hospital~~) attended the deceased from ____ 19 70 to 2-21 19 89, that (I) (~~we~~) last saw the deceased alive on 2-21 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (did not) view the body after death.

22b. SIGNATURE: Charles Spencer M.D. — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-22-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles C. Spencer — 22e. ADDRESS: 1198 Kenly Ave Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 24, 1988	Manor Church Cemetery	Tilghmanton, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 22 89	Gene Davidson Ramsey

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

023636 FEB 23 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06106
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Elizabeth Frances Britner	2a. DATE OF DEATH MONTH DAY YEAR	2-12-89	2b. HOUR	1400 M
3. SEX	FEMALE	4. RACE	WHITE	5. DATE OF BIRTH MONTH DAY YEAR	1 23 1911
6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Washington MD.				
10. CITY OR TOWN OF DEATH	Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housekeeping
12b. KIND OF BUSINESS OR INDUSTRY	Housewife				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Washington	13c. CITY OR TOWN	Williamsport
13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS	Milestone Garden Apts. 21795		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Charles H. Schamel	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Virginia C. Stotler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	214-54-0058
17. INFORMANT ADDRESS	Louise B. Luther 127 Harvard Rd. Hag. MD 21740				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from ____ 19____ to ____ 19____, that (I) (~~we~~) last saw the deceased alive on 2/12 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	George Mennon II M.D.	DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	Feb. 15, 1989	23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Mem. Park
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Williamsport Wash. MD			
24. FUNERAL DIRECTOR NAME / ADDRESS	MAJOR M. OSBORNE P.O. BOX 348 WILLIAMSPORT, MD 21795	25a. DATE REC'D. BY REGISTRAR	FEB 14 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

02363 | FEB 23 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06107
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Mabel	Middle: A	Last: Brooks	2a. DATE OF DEATH Month: Feb	Day: 10	Year: 89
2b. HOUR: 8:00 p.m.					
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month: Feb. Day: 27 Year: 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS	If under 1 year: Months / Days	If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housekeeper	12b. KIND OF BUSINESS OR INDUSTRY: Domestic		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	630 N. Prospect St. 21740

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Mason / / Grisby	Maggie / / Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		227-22-0248	Luther I Brooks, Jr.	628 N. Prospect St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Coronary Vessel Disease — 15 years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 6, 19 89, to Feb 10, 19 89, that (I) (we) last saw the deceased alive on 19 88, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert Brull	MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/10/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert Brull	1459 Potomac Ave. Hagerstown

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/14/89	Cedar Lawn Memorial Park	Hagerstown Washington Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gerald N. Minnich	305 N. Potomac Street Hagerstown, Maryland	FEB 13 '89	Julia Davidson Rondeau

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it must be presented to the cemetery or crematory official prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, either traumatic event, the medical examiner must be notified at once.

BP 1

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06108
REG. NO.

023634 FEB 1989

1. DECEASED NAME (Type or Print) — First: Kathleen; Middle: Veronica; Last: Burgan

2a. DATE OF DEATH — Month Day Year: February 11, 1989

2b. HOUR: M

3. SEX: female

4. RACE: white

5. DATE OF BIRTH — Month Day Year: January 30, 1926

6. AGE (In years last birthday): 63 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (State or Foreign Country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address): Washington County Hospital

12a. USUAL OCCUPATION (Type of work for most of working life): housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (If nursing home or other institution, give residence before admission)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 1515 Kensington Drive 21740

14. FATHER'S NAME — First: John; Middle: ; Last: Prosper

15. MOTHER'S MAIDEN NAME — First: Frances; Middle: ; Last: Novella

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown): no (If yes, give war or dates):

16b. SOCIAL SECURITY NO.: 220-18-1656

17. INFORMANT — ADDRESS: Everett E. Burgan, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	Respiratory failure	24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia of right lung	10 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Extensive liver carcinoma	unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Cholelithiasis

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY — Hour A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 Part I or Part 2)

21d. INJURY OCCURRED — While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)

21f. LOCATION — Street; City or Town; County; State

22a. I certify that (I) (~~this hospital~~) attended the deceased from ____ 19____ to ____ 19____ that (I) (~~we~~) last saw the deceased alive on 2/11 19 89 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas V Craig — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/12/89

22d. PHYSICIAN'S NAME (Type or Print):

22e. ADDRESS: 208 E Antietam Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE: Feb. 14, 1989

23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Park

23d. LOCATION — City or Town; County; State: Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR — NAME: MINNICH FUNERAL HOME — ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740

25a. DATE REC'D. BY REGISTRAR: FEB 14 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Rondeau

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

022621 FEB 1 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06109
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ELWOOD MIDDLE: M. LAST: BURKHOLDER		2a. DATE OF DEATH MONTH DAY YEAR: 2-2-89	2b. HOUR: 2200 P M
3. SEX: M	4. RACE: Cau	5. DATE OF BIRTH MONTH DAY YEAR: 12 11 82	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS; IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): USA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wash. MD.
10. CITY OR TOWN OF DEATH: Hagerst	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wash. C/Hsp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): R.R. conductor	12b. KIND OF BUSINESS OR INDUSTRY: Railroad
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Wash.	13c. CITY OR TOWN: Hagerst	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET ADDRESS: 241[illegible] Burhead Rd.
14. FATHER'S NAME FIRST: Franklin MIDDLE: LAST: Burkholder		15. MOTHER'S MAIDEN NAME FIRST: Laura MIDDLE: Virginia LAST: Wise	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-09-6935	17. INFORMANT: Clt	ADDRESS: Eva Burkholder see # 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Resp arrest.
DUE TO, OR AS A CONSEQUENCE OF (b): metastatic ca colon
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 89, to 2/2 19 89, that (I) (we) last saw the deceased alive on 2/2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑		22c. DATE SIGNED: 2/3/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Gerald J. Sgrillo	22e. ADDRESS: 346 Mill St Hag. Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-6-89	23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Memorial Pk	23d. LOCATION CITY OR TOWN: Hagerstown,	COUNTY: Maryland STATE
24. FUNERAL DIRECTOR NAME: Gerald N. Minnich	ADDRESS: 305 N. Potomac St. Hagerstown, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 7 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

BP 8

DHMH - 16 50M 1/81 (VRA 15, 4)

023081 FEB 7 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 06 110

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Sarah	Elizabeth	CARNEY	February 12, 1989	5:35PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	8 14 1891	97 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	U.S.A.		Washington County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Williamsport	Homewood Nursing Home		Seamstress	self-employed	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Baltimore	Catonsville	YES ☐ NO ☒	4209 Fordham Rd. 21229

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel	M.	Kendle	Mary		Carty

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-22-1527	Dorothy Esender	4209 Fordham Rd. 21229

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/11, 19 88, to 2/12, 19 89, that (I) (we) last saw the deceased alive on 1/31, 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Allan W. Dick MD	1610 Oak Hill Ave Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2-15-89	Loudon Park Cemetery	Baltimore MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229	FEB 15 1989	Julia Davidson-Randall

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

023791 FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06 111
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: Thora; Middle: Bertha B.; Last: CLINE				2a. DATE OF DEATH Month Day Year: 02-18-1989	2b. HOUR: 1700 PM
3. SEX: female	4. RACE: white	5. DATE OF BIRTH Month Day Year: June 29, 1912		6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Washington Co. MD.	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): assembly	12b. KIND OF BUSINESS OR INDUSTRY: aircraft
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 2377 Pennsylvania Ave. 21740	
14. FATHER'S NAME First: Eugene; Middle; Last: Oden			15. MOTHER'S MAIDEN NAME First: unknown; Middle; Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): mp	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Janet Litton, Hagerstown, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABDUL WAHEED, MD — 22e. ADDRESS: 1610 - Oak Hill Ave. Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: Feb. 21, 1989	23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR: FEB 27 '89	25b. REGISTRAR'S SIGNATURE: [signature]

023789 FEB 16

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06112
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Anna	Margaret	Cochrane	February 10, 1989	6:15p M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	January 16, 1885	104 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		Washington County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Boonsboro, MD	Reeder's Memorial Home	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	11 West Baltimore Street 21740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	Franklin	Uhler	Susan	B.	Izer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	- - -	076-14-3879	Anna M. Krouse, Williamsport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from _____, 19 2-8-89, to present, 19 _____, that (I) (we) last saw the deceased alive on 2-7-89, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
R Guedenet		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R. Guedenet M.D.	100 Geeting Lane, Keedysville, Md. 21756

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-14-89	Rose Hill Cemetery	Hagerstown, Washington, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Funeral Home, Inc.	Hagerstown, Md.	FEB 15 '89	Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

024460 MAR - 1 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06113
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Edgar	Scott	CORNELIUS	
2a. DATE OF DEATH — MONTH DAY YEAR	February 17, 1989			2b. HOUR: 8:00am
3. SEX	Male			
4. RACE	White			
5. DATE OF BIRTH — MONTH DAY YEAR	July 11 1913			
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PA			
7b. CITIZEN OF WHAT COUNTRY?	USA			
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐				
9. BALTIMORE CITY OR COUNTY OF DEATH	Washington MD.			
10. CITY OR TOWN OF DEATH	Hagerstown			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Western Maryland Center			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	forklift operator			
12b. KIND OF BUSINESS OR INDUSTRY	army depot			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	PA			
13b. COUNTY	Huntingdon			
13c. CITY OR TOWN	Three Springs			
13d. INSIDE CITY LIMITS? YES ☐ NO ☒				
13e. STREET ADDRESS	RD 1 Box 516			99999
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Orlando		Cornelius	
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Jane		Donaldson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No			
(IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO.	209-01-4981			
17. INFORMANT — ADDRESS	Walter Cornelius RD1 Box 2451, Three Springs, P			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcinoma of the prostate with widespread bony metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 16 months

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hypertensive arteriosclerotic heart disease;diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ☒ (this hospital) attended the deceased from October 15, 19 87, to February 17 19 89, that (I) (~~XX~~) last saw the deceased alive on February17, 19 89, and that in (my) (~~XX~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~XX~~ (did) (~~did not~~)) view the body after death.

22b. SIGNATURE	Fe U. Porciuncula	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED	2/17/89		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Fe U. Porciuncula, M.D.		
22e. ADDRESS	1500 pennsylvania Ave., Hagerstown, MD 21740		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	burial	23b. DATE	2-20-89	
23c. NAME OF CEMETERY OR CREMATORY	Three Springs Cemetery			
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Three Springs	Hunt.	PA	
24. FUNERAL DIRECTOR — NAME / ADDRESS	Martin R. Brown Funeral Home, Inc., Orbisonia, PA			
25a. DATE REC'D. BY REGISTRAR	MAR 1 1989	25b. REGISTRAR'S SIGNATURE	Julia Davidson-Randall	

99999

BP

024561 MAR 3 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06114 REG. NO

1. DECEASED NAME (TYPE OR PRINT) First: William Middle: J. Last: CORNELL

2a. DATE OF DEATH Month Day Year: 2 24 89

2b. HOUR: 0340 A M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH Month Day Year: May 25,1911

6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kyser, W. Va.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Insurance Manager- Agent

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 203 Allen Ave. 21740

14. FATHER'S NAME First: Edgar Middle: B. Last: Cornell

15. MOTHER'S MAIDEN NAME First: Elizabeth Middle: J. Last: Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes

(IF YES, GIVE WAR OR DATES): W. W. Two

16b. SOCIAL SECURITY NO.: 232-10-5138

17. INFORMANT: Mrs. N. Virginia Cornell, ADDRESS: 203 Allen Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of the lung

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2-23 19 89 to 2-24 19 89, that (I) (we) last saw the deceased alive on 2-23 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Emily Wagshal M.D. DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): E. M. Wagshal M. D.

22e. ADDRESS: 1825 Howell Rd., Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-27-89

23c. NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery

23d. LOCATION STREET OR R.F.D. CITY OR TOWN COUNTY STATE: Boonsboro, Wash. Co., Md.

24. FUNERAL DIRECTOR NAME: Bast Funeral Home John H. Bast, Jr. Boonsboro, Md. 21713

25a. DATE REC'D. BY REGISTRAR: FEB 27 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

024560 MAR B-89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06 115
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: HAROLD	MIDDLE: Marion	LAST: Dill	2a. DATE OF DEATH MONTH DAY YEAR: Feb 27 1989	2b. HOUR: 11:45 A M	
3. SEX: male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: February 11, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): security	12b. KIND OF BUSINESS OR INDUSTRY: cement	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	743 Spruce Street 21740

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Robert / / Dill	Emma / / Reaker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	W.W.II	215-14-2735	Barbara Beach, Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Exsanguination	min
DUE TO, OR AS A CONSEQUENCE OF (b)	Massive hemoptysis	min
DUE TO, OR AS A CONSEQUENCE OF (c)	Tumors of right lung - Carcinoma?	months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2-24- 19 89 to 2-27 19 89, that (I) (we) last saw the deceased alive on 2-27 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Harold R Tritch Jr MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-28-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
HAROLD R. TRITCH JR MD	348 Mill ST Hagerstown Md 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	March 2, 1989	Cedar Lawn Mem. Park	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 28 '89	Jackie Davidson-Wendell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

024559 MAR - 2 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06116

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Lewis — MIDDLE: W. — LAST: FORSYTH

2a. DATE OF DEATH — MONTH DAY YEAR: February 24, 1989

2b. HOUR: 2 44 P.M.

3. SEX: M

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: 02 - 16 - 1890

6. AGE (IN YEARS LAST BIRTHDAY): 99 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington Co. MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Co. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Washington

13c. CITY OR TOWN: Clear Spring

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Rt 3 Box 82 21722

14. FATHER'S NAME — FIRST: Isaac — MIDDLE: — LAST: Forsyth

15. MOTHER'S MAIDEN NAME — FIRST: Elizabeth — MIDDLE: — LAST: Barns

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES — (IF YES, GIVE WAR OR DATES): WW I

16b. SOCIAL SECURITY NO.: 214-36-0622

17. INFORMANT: Donald Forsyth — ADDRESS: Rt 3 Box 83 Clear Spring, Md 21722

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease Dreeant M.I. years / Mos 8

DUE TO, OR AS A CONSEQUENCE OF (c): Arthrosclerosis, generalized

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 29 Nov. 19 88 to 24 Feb 19 89 that (I) (we) last saw the deceased alive on 23 Feb 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED: 26 Feb 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): W. N. Fender

22e. ADDRESS: 138 E. Antietam St. Hagerstown MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-28-89

23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Park

23d. LOCATION — CITY OR TOWN: Hagerstown COUNTY: Wash. STATE: MD

24. FUNERAL DIRECTOR — NAME: Thompson Funeral Home Inc. ADDRESS: Clear Spring MD

25a. DATE REC'D. BY REGISTRAR: FEB 28 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rockwell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

-023635 FEB 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06117
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret	MIDDLE: Helen H.	LAST: Fox	2a. DATE OF DEATH MONTH: 2	DAY: 11	YEAR: 89
2b. HOUR: 6:20 PM					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 5	DAY: 3	YEAR: 09	
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Colton Villa Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): clerk	12b. KIND OF BUSINESS OR INDUSTRY: grocery		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 11 W. Baltimore St. 21740	
14. FATHER'S NAME FIRST: John	MIDDLE: E.	LAST: Fox	15. MOTHER'S MAIDEN NAME FIRST: Daisy	MIDDLE: M.	LAST: Duncan
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-09-0082	17. INFORMANT: Anna M. Ritter	ADDRESS: Hagerstown, Md. 289 Frederick St.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b): Dysphagia
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12-9-88 19 88 to 19 , that (I) (we) last saw the deceased alive on 2-9-89 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-15-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): E.E. Landis Gabbert M.D. 22e. ADDRESS: 332 John Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: Feb. 14, 1989	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME / ADDRESS: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D. BY REGISTRAR: FEB 14 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 2

DHMH - 1650M 1/81 (VRA 15, 4)

024558 MAR -3 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 89 061183

1. DECEASED NAME (TYPE OR PRINT) First: Sarah	Middle: C	Last: Baines	2a. DATE OF DEATH Month/Day/Year: 2-23-89	2b. HOUR: 1425 M	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month/Day/Year: 1/15/29	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD.		
10. CITY OR TOWN OF DEATH: Hag. Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Wash.	Hagerstown	YES ☒ NO ☐	667 Pennsylvania Ave. 21740

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Thomas NMN Rideout	Annie NMN Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		162-22-5316	Linda Keith 951-B Main Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intraventricular hypertensive hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Brain tumor (Olfactory Groove Meningioma)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2/21/89	Brain tumor	YES ☐ NO ☒	YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/16, 19 89, to 2/23, 19 89, that (I) (we) last saw the deceased alive on 2/23, 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
A.F. Abdullah	M.D	☒ / ☐ / ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A.F. Abdullah	318 N. Potomac, Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3/1/89	Rose Hill Cem.	Hagerstown Wash. Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Dennis L. Davis Smithsburg, Md. 21783	FEB 24 '89	Lisha Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

124557 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06 119 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: George	MIDDLE: William	LAST: GARDENHOUR Sr.	2a. DATE OF DEATH MONTH: 2	DAY: 21	YEAR: 89
2b. HOUR	3:05 P.M.					
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	Jan. 12, 1899	
6. AGE (IN YEARS LAST BIRTHDAY)	90 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		
9. BALTIMORE CITY OR COUNTY OF DEATH	Washington MD.					
10. CITY OR TOWN OF DEATH	Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Ravenwood Lutheran Village	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Orchardist	12b. KIND OF BUSINESS OR INDUSTRY: Orchards

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Wash.	Smithsburg	YES ☐ NO ☒	Rt 2 Box 433	21783

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Boaz		Gardenhour	Ella		Cox

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		220-09-7501	G. William Gardenhour III	Smithsburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma thyroid	2 wks.
DUE TO, OR AS A CONSEQUENCE OF (c)	Carcinoma thyroid Ravenwood Lutheran Village	5 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 5-1 19 55, to 2-21 19 89, that (I) (we) last saw the deceased alive on 2-13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Charles F. Hess	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-22-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Charles F. Hess MD	Smithsburg Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 24, 1989	Smithsburg Cemetery	Smithsburg, Wash, Md.

24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Davis Funeral Home	Smithsburg, Md.	FEB 23 '89	Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

025188 MAR 1 4 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06120 REG. NO.

4

1. DECEASED NAME (TYPE OR PRINT) FIRST: DAISY	MIDDLE: B	LAST: GRAMS	2a. DATE OF DEATH MONTH: 1	DAY: 21	YEAR: 89	2b. HOUR: 6 20 PM
3. SEX: F	4. RACE: C	5. DATE OF BIRTH MONTH: 3	DAY: 18	YEAR: 07	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Brunswick, MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.			
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Colton Villa Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Homemaker			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Rohrersville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Route 67	21779	
14. FATHER'S NAME FIRST: Thomas	MIDDLE: Leonard	LAST: Harper	15. MOTHER'S MAIDEN NAME FIRST: Delia	MIDDLE: Virginia	LAST: Myers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219626231	17. INFORMANT: Frances L. Harmon	ADDRESS: P.O. Box 88 Rohrersville, Md. 21779		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): _____

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF (c): _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/6 19 88 to _____ 19 _____, that (I) (we) last saw the deceased alive on 1-21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1-22-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): E.B. Kaadizadeh MD. — 22e. ADDRESS: 38[illegible] [illegible] Rd, Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	1/23/1988	Smithsburg Crematory	Smithsburg / Washington / MD

24. FUNERAL DIRECTOR (NAME)	(ADDRESS)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John T. Williams Funeral Home	100 Petersville Rd Brunswick, MD 21716	FEB 03 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

022620 FEB 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06121
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Robert MIDDLE L. LAST GRIMSLEY

2a. DATE OF DEATH: MONTH 2 DAY 3 YEAR 89

2b. HOUR: 9:40 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH March DAY 23 YEAR 1932

6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Western Maryland Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Officer

12b. KIND OF BUSINESS OR INDUSTRY: Police

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 218 Frederick Street 21740

14. FATHER'S NAME: FIRST John MIDDLE David LAST Grimsley

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE Louise LAST Swartz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 1951-1955

16b. SOCIAL SECURITY NO.: 217-28-2260

17. INFORMANT: Constance L. Grimsley ADDRESS: 218 Frederick St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebrovascular Accident

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that [X] (this hospital) attended the deceased from 8/30 19 88 to 2/3 19 89, that (I) [XXX] last saw the deceased alive on 2/3 19 89, and that in (my) [XXX] opinion death occurred on the date and hour and from the causes stated above, (I) [XXX] (did) [XXX] view the body after death.

22b. SIGNATURE: Rose Marie Chan, M.D. DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]

22c. DATE SIGNED: 2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROSE MARIE CHAN

22e. ADDRESS: Western Maryland Center, Hagerstown MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/7/89

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION: CITY OR TOWN Hagerstown; COUNTY Washington; STATE Md.

24. FUNERAL DIRECTOR: NAME Gerald N. Minnich; ADDRESS 305 N. Potomac Street Hagerstown, Maryland

25a. DATE REC'D BY REGISTRAR: FEB 7 89

25b. REGISTRAR: Judith Beachtown Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

1-VA

023788 FEB 26 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 0 6 1 2 2

1. DECEASED NAME (TYPE OR PRINT) FIRST: Sarah MIDDLE: Margaret LAST: Hammond			2a. DATE OF DEATH MONTH: 2 DAY: 18 YEAR: 89	2b. HOUR: 0325 M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 8 DAY: 5 YEAR: 1901	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS HOURS: MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housekeeping	12b. KIND OF BUSINESS OR INDUSTRY: housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Sharpsburg	YES ☒ NO ☐	117 E. Main St. 21782

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
Noah Richardson Bear	Jesse Viola Norris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		218-50-4036	Linda Knight	Dargan, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic cardiac disease

DUE TO, OR AS A CONSEQUENCE OF (c): acute posterior wall myocardial infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Severe alzheimers type dementia, dehydration

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/19 19__ to 2/17/89 19__, that (I) (we) last saw the deceased alive on 4/19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
R.L. Kugler	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R.L. Kugler MD	Wyand Cane Keedysville, Md 21756

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb. 21, 1989	Mt View Cemetery	Sharpsburg / Wash. / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR
Major M. Osborne P.O. Box 348 Wmspt, MD 21795	FEB 21 89	[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

023628 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06123
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Eva	Elizabeth E	Hassler	02	07	89 / 6:50 pm
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Female	White	6 15 04	84 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Washington MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Colton Villa Nursing Center		housewife		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	241 N. Locust St. 21740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	W.	Shoemaker	Malinda		Kline

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		217-10-3324	Leon Hassler, 324 Devonshire Rd.	Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Arteriosclerotic Cerebral Vascular disease with stroke

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/24 19 88 to Feb 7 19 89, that (I) (we) last saw the deceased alive on above (I) (we) (did) (did not) view the body after death. 2/8/89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Robert Brull	MD		2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert Brull MD	1459 Potomac Ave. Hagerstown MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 10, 1989	Rest Haven Cemetery	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 9 '89	Gina Brubaker-Randall

023787 FEB 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06 124
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: June	MIDDLE: Larose L.	LAST: Hauver	2a. DATE OF DEATH MONTH: 02	DAY: 13	YEAR: 89
2b. HOUR: 10 15 AM					
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH MONTH: 9	DAY: 11	YEAR: 19	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Colton Villa Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): hostess	12b. KIND OF BUSINESS OR INDUSTRY: restaurant		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Fairplay	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Route 1, Box 160 21733	
14. FATHER'S NAME FIRST: Harry	MIDDLE:	LAST: French	15. MOTHER'S MAIDEN NAME FIRST: Thelma	MIDDLE:	LAST: Sweeney
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 199-07-1807	17. INFORMANT ADDRESS: Barbara Bertrand, Great Falls, Virginia		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart failure
DUE TO, OR AS A CONSEQUENCE OF (c): Atrial fibrillation
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying couse last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ABDUL WAHEED, MD	1610 - OAK HILL AVE. HAGERSTOWN, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
cremation	Feb. 14, 1989	Smithsburg Crematory	Smithsburg, Wash., Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME	415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 21 89	Gina Davidson-Randall

J24556 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 89 06125

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Harvey	L.	HOTTLE

2a. DATE OF DEATH: MONTH 2 DAY 25 YEAR 89 — 2b. HOUR 0725 A

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	White	May 15 1919	69 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Washington MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Washington County Hospital	Sawer	Jamison Door Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	11 W. Baltimore St. 21740

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Clarence Adolph Hottle	Zelda L. Robinson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-18-9566A	Linda L. Kelley	19 Woodlawn Drive Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIVERTICULITIS; DEHYDRATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 02-24 19 89 to 02-25 19 89, that (I) (we) last saw the deceased alive on 02-24 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	MD		02-25-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
BARRY M. COHEN, MD	HAGERSTOWN, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/28/89	Cedar Lawn Memorial Park	Hagerstown Washington Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gerald N. Minnich	305 N. Potomac Street Hagerstown, Maryland	FEB 27 89	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

0237[illegible] FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06126
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First Doris Middle Gertrude Last Hutzell

2a. DATE OF DEATH: Month February Day 12 Year 1989

2b. HOUR: 1620 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month 12 Day 3 Year 1914

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. If under 1 year: Months ____ Days ____ If under 24 hrs.: Hours ____ Min. ____

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Boonsboro

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: Rt. 3 Box 107 21713

14. FATHER'S NAME: First John Middle Luther Last Ridenour

15. MOTHER'S MAIDEN NAME: First Jennie Middle Gertrude Last Welty

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-16-0895

17. INFORMANT: Esther J. Hutzell ADDRESS Rt. 3 Box 7 Boonsboro, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute left lung lobe pneumonia — Approximate interval between onset and death: 24 hours

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Cardiac attack — 6 days

DUE TO, OR AS A CONSEQUENCE OF (c): Parkinsons Disease — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertensive cardiovascular Disease; Degenerative joint Disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1978 to 2/12/89, that (I) (we) last saw the deceased alive on 2/12/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edson B. Moody M.D. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Edson B. Moody M.D.

22e. ADDRESS: 1190 Mt. Aetna Rd. Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2 - 14-1989

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematorium

23d. LOCATION: CITY OR TOWN Smithsburg COUNTY Washington STATE Md.

24. FUNERAL DIRECTOR: NAME Douglas A. Fiery Funeral Home ADDRESS Bast Rfd. 4 Box 7 Boonsboro Md.

25a. DATE REC'D BY REGISTRAR: FEB 15 89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

023624 FEB 23 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06127
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pieced [illegible] with the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible], the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: John	MIDDLE: Maurice M	LAST: Hutzell	2a. DATE OF DEATH MONTH DAY YEAR: 2-7-89	2b. HOUR: 10:10 AM	
3. SEX: Male	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 12 13 98	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): deputy Register of Wills (state)	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 237 Pangborn Boulevard 21740	
14. FATHER'S NAME FIRST: John	MIDDLE: Calvin	LAST: Hutzell	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: Lizzie	LAST: Stine
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): WWI	16b. SOCIAL SECURITY NO.: 217-10-3032	17. INFORMANT ADDRESS: Irene Hutzell, Hagerstown, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Postoperative dysphagia, metastatic carcinoma of prostate

19a. DATE OF OPERATION: 1-28-89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Left femoral fracture	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 86 to 2-7 19 89 that (I) (we) last saw the deceased alive on 2-7 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles C. Spencer DEGREE: MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-7-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles C. Spencer — 22e. ADDRESS: 1198 Kenly Ave Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: Feb. 10, 1989	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D. BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

023613 FEB 23 89

FOR STATE REGISTRAR

REG. NO 89 006123

1. DECEASED NAME (TYPE OR PRINT): First David Middle A Last Ingram
2a. DATE OF DEATH: Month 2 Day 3 Year 89
2b. HOUR: 1005 M
3. SEX: Male
4. RACE: caucasion
5. DATE OF BIRTH: Month 9 Day 11 Year 02
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS
If under 1 year: Months / Days
If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD.
10. CITY OR TOWN OF DEATH: Hagerstown
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): parole officer
12b. KIND OF BUSINESS OR INDUSTRY: Dept. of Justice

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Washington
13c. CITY OR TOWN: Hagerstown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 202 Cambridge Dr. 21740

14. FATHER'S NAME: First David Middle Albert Last Ingram
15. MOTHER'S MAIDEN NAME: First Margaret Middle Last Hoffmaster
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 212 14 6493
17. INFORMANT ADDRESS: Mrs. Arlette Ingram, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — Approximate interval between onset and death: few min
DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia — few days
DUE TO, OR AS A CONSEQUENCE OF (c): COPD — yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: ASCVD

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1.10 19 89 to 2-3 19 89, that (I) (we) last saw the deceased alive on 2-3 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2.6.89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): VASANT DATTA, MD
22e. ADDRESS: 334 MILL ST HAGERS TOWN, MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): entombment
23b. DATE: Feb. 6, 1989
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Mausoleum
23d. LOCATION: CITY OR TOWN / COUNTY / STATE: Silver Spring, Wash., Md.
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740
25a. DATE REC'D. BY REGISTRAR: FEB 8 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

023785 FEB 26 89

1b- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06129 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: [illegible] certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use [illegible] cannot permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or [illegible] shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: LUTHER	LAST: KEPLER	2a. DATE OF DEATH MONTH DAY YEAR: FEB. 18, 1989	2b. HOUR: 10 p M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 8 26 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS HOURS MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Boonsboro, MD	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD.		
10. CITY OR TOWN OF DEATH: BOONSBORO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): REEDERS MEMORIAL HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Custodian	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Boonsboro	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 208 Della Lane 2173
14. FATHER'S NAME FIRST: John	MIDDLE: H.	LAST: Kepler	15. MOTHER'S MAIDEN NAME FIRST: Sadie	MIDDLE: E. LAST: Schildtknecht (Kepler)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 217-32-5070	17. INFORMANT ADDRESS: Linda Grove, 208 Della Lane, Boonsboro, MD	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): probable massive cerebro-vascular accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): e

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 2-14-89 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. R Guedenet M.D.	22e. ADDRESS: 100 Geeting Lane Keedysville Md. 21756	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-21-1989	23c. NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery	23d. LOCATION CITY OR TOWN: Boonsboro COUNTY: Washington STATE: Md.
24. FUNERAL DIRECTOR NAME: Douglas A. Fiery	ADDRESS: East Rfd. 4 Box 7 Funeral Home Boonsboro, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

B23629 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 006130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any accident or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	William	MIDDLE Edward	LAST King	2a. DATE OF DEATH MONTH DAY YEAR	2 - 8 - 89
2b. HOUR	1:20 AM				
3. SEX	MALE	4. RACE	C	5. DATE OF BIRTH MONTH DAY YEAR	03 09 02
6. AGE (IN YEARS LAST BIRTHDAY)	86 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Washington MD.				
10. CITY OR TOWN OF DEATH	Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Colton Villa Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	engineer
12b. KIND OF BUSINESS OR INDUSTRY	Pangborn Corp.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Washington	13c. CITY OR TOWN	Hagerstown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS	929 Dewey Avenue 21740			
14. FATHER'S NAME FIRST	James	MIDDLE E.	LAST King	15. MOTHER'S MAIDEN NAME FIRST	Rose
MIDDLE	L.	LAST	Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	214-09-5996
17. INFORMANT	William E. King, Jr., Hagerstown, Md.	ADDRESS			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED	2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	ABDUL WAHEED MD	22e. ADDRESS	1610- OAK HILL AVE. HAGERSTOWN. MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	burial	23b. DATE	Feb.11,1989	23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE	Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS	MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D BY REGISTRAR	FEB 10 89	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

22632 FEB 14 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06131
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: Anna Middle: Mary Last: KLINE				2a. DATE OF DEATH Month Day Year: February 2, 1989	2b. HOUR: 6 40 PM
3. SEX: female	4. RACE: white	5. DATE OF BIRTH Month Day Year: May 11, 1899	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): female	7b. CITIZEN OF WHAT COUNTRY?: white	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WASHINGTON		MD.
10. CITY OR TOWN OF DEATH: HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AVALON HOME INC.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): hand ironer	12b. KIND OF BUSINESS OR INDUSTRY: laundry	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	304 S. Locust St. 21740

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Henry Aldridge	Laura Metz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		213-12-7545	Dorothy J. Aldridge, Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from October 19 84, to February 19 89, that (I) (we) last saw the deceased alive on December 15, 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Howard N. Weeks, M.D.	580 Northern Avenue Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 4, 1989	Rose Hill Cemetery	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 6 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

023784 FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06132
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes," Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: EVELYN	MIDDLE: Louise	LAST: KNODE	2a. DATE OF DEATH MONTH: FEB	DAY: 17	YEAR: 89
2b. HOUR: 7:25 AM					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 31, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Keedysville, Md.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Williamsport	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Williamsport Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Keedysville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: Main Street 21756	
14. FATHER'S NAME FIRST: Travis	MIDDLE: D.	LAST: Knode, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: Agnes	LAST: Jones
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 165-52-0108	17. INFORMANT: John Lindley,	ADDRESS: 3301 Sherwood Dr. Largo, Fla. 34641	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-6 19 86 to 2-17 19 89 that (I) (we) last saw the deceased alive on 2-16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ted Howe — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): TED E. HOWE — 22e. ADDRESS: OWNEY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2-17-89	23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Smithsburg, Wash Co., Md.
24. FUNERAL DIRECTOR NAME: John H. Bast, Jr.	ADDRESS: Bast Funeral Home Boonsboro, Md. 21713	25a. DATE REC'D BY REGISTRAR: FEB 17 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 1

DHMH - 16 60M 7/84
(VRA 15, 4)

024555 MAR 2 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06133
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Maurice	Middle: H	Last: LEWIS	
2a. DATE OF DEATH Month/Day/Year: 2-22-89	2b. HOUR: 4:10 AM		
3. SEX: male	4. RACE: white	5. DATE OF BIRTH Month/Day/Year: October 31, 1899	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.
10. CITY OR TOWN OF DEATH: Williamsport	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Williamsport Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): farmer	12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Washington	Hagerstown	YES ☒ NO ☐	854 Snyder Avenue 21740

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jerone	Henry	Lewis	Sarah	Ellen	Butts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		218-24-9047	Catherine Andrews, Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-9, 19 89, to 2-22, 19 89, that (I) (we) last saw the deceased alive on 2-16, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Ted E. Howe MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
TED E. HOWE	OLNEY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 24, 1989	Rest Haven Cemetery	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME	415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 22 '89	Julia Davidson-Rondeau

BP 2

DHMH - 16 60M 7/84
(VRA 15, 4)

024554 MAR - 3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06134
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT): First Joseph; Middle S.; Last Lizor Sr.

2a. DATE OF DEATH: Month 02; Day 27; Year 89

2b. HOUR: 2255 M

3. SEX: male

4. RACE: white

5. DATE OF BIRTH: Month 2; Day 17; Year 1911

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington Co. MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Custodian

12b. KIND OF BUSINESS OR INDUSTRY: St. mary's Church

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Washington

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS 21740: 46 Woodcrest Avenue

14. FATHER'S NAME: First Clifford; Middle Samuel; Last Lizor

15. MOTHER'S MAIDEN NAME: First Rose; Middle Burndetta; Last Sanders

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes

(IF YES, GIVE WAR OR DATES): W. W. Two

16b. SOCIAL SECURITY NO.: 214-09-6686

17. INFORMANT: Minnie E. Lizor, 46 Woodcrest Ave. Hagerstown, Md. 21740

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — Approximate interval between onset and death: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Cardiomyopathy — years

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic renal failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-27-89 to 2-27-89, that (I) (we) last saw the deceased alive on 2-27-89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles C. Spencer DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2-28-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles C. Spencer

22e. ADDRESS: 1198 Kenly Ave Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 3-2-89

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION: CITY OR TOWN: Hagerstown; COUNTY: Wash. Co., Md.

24. FUNERAL DIRECTOR: NAME: John H. Bast, Jr. ADDRESS: Bast Funeral Home, Boonsboro, Md. 21713

25a. DATE REC'D. BY REGISTRAR: FEB 28 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsey

024122 FEB 29 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06135
REG. NO

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
	Michael	Andrew	Lynch	February		16	89	0634 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
		MONTH DAY YEAR		MONTHS	DAYS	HOURS	MIN.
Male	White	Sept. 14, 1965	23 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	Washington Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Washington County Hospital	Clerk	Bingo World

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Anne Arundel	Hanover	YES ☐ NO ☒	7847 Metacomet Road 21076

14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST
	Robert	John	Lynch		Shirley	A.	Nichols

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Father) ADDRESS	
No	N/A	192.58.7478	Mr. Robert J. Lynch	Same as #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Osgood MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
A. WAKEFIELD, MD	1610 - OAK HILL AVE. HAGERSTOWN, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 21, 1989	Washington Nat'l. Cem.	Suitland	P.G.	Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R. H. Hopkins Singleton Funeral Home	Glen Burnie, Maryland	FEB 21 1989	Julia Davidson Rankin

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023157 FEB 17 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06 136 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Mabel	K	MATHER	2	4	89	10:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
F	C	01	31	07	82 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Washington Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Colton Villa Nursing Home	Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Washington	Hagerstown	YES ☐ NO ☒	750 Dual Highway 21740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Roman		Wolfe	Laura		Kuhns

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-03-3936	Mrs. Irene Ridenour Box 35	Cavetown, Md. 21720

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Heart Failure	1 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Cardiovascular Disease	10 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-13 19 66 to 2-4 19 89, that (I) (we) last saw the deceased alive on 1-30 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Charles F. Hess	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-6-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Charles F. Hess M.D	Smithsburg Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/8/89	Smithsburg Cemetery	Smithsburg Washington Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Mark Coon	50 S. Broad St. Waynesboro, Pa. 17268	FEB 13 1989	Julia Davidson Randall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

022957 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06 137
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Alice — MIDDLE: Pearl McCarty — LAST: McCarthy

2a. DATE OF DEATH — MONTH: 2 — DAY: 5 — YEAR: 89

2b. HOUR: 2:27 PM

3. SEX: Female

4. RACE: Cauc.

5. DATE OF BIRTH — MONTH: 4 — DAY: 2 — YEAR: 96

6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington, MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Colton Villa Nursing Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Washington — 13c. CITY OR TOWN: Big Pool — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: Rt. #1 2/711

14. FATHER'S NAME — FIRST: Thomas — MIDDLE: A. — LAST: Hull

15. MOTHER'S MAIDEN NAME — FIRST: Mary — MIDDLE: A. — LAST: Reed

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 217 32 7088

17. INFORMANT — ADDRESS: Roy W.McCarthy 37A E.Main St.Hancock,Md.21750

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary Arrest -
DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Abdul Waheed MD

22e. ADDRESS: 1610 Oak Hill Avenue Hagerstown MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02/08/89

23c. NAME OF CEMETERY OR CREMATORY: Parkhead

23d. LOCATION — CITY OR TOWN: Big Pool — COUNTY: Washington — STATE: Md.

24. FUNERAL DIRECTOR — NAME: [illegible] — ADDRESS: 141 W.Main St,Hancock,Md.21750

25a. DATE REC'D. BY REGISTRAR: FEB 13 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

6

BP_____

DHMH - 16 50M 1/81
(VRA 15, 4)

Items 18a, 22a per M.E. Film G650 4/7/89 CC

24553 MAR -3 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 061338

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)	FIRST: WILLIAM	MIDDLE: L.	LAST: McCOMAS	2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 2 DAY 23 YEAR 19 89	2b. HOUR M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH May DAY 2 YEAR 1953	6. AGE (IN YEARS LAST BIRTHDAY): 35 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 23 YEAR 19 89	2d. HOUR 6:34 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): None	12b. KIND OF BUSINESS OR INDUSTRY: None		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt. 12 Box 179 Showalter Rd. Hag., Md.	
14. FATHER'S NAME: FIRST William MIDDLE L. LAST McComas, Sr.			15. MOTHER'S MAIDEN NAME: FIRST Irene MIDDLE Ruth LAST McAllister		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-76-1945	17. INFORMANT: Elizabeth Rodwell	ADDRESS: 2111 Penna. Ave. Hagerstown, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopeumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if ony, which gave rise to immediate couse (a) stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Non-communicating hydrocephalus due to aqueductal stenosis and severe mental retardation (clinical)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-25-89

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/28/89	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION CITY OR TOWN: Hagerstown COUNTY: Wash., STATE: Maryland	
24. FUNERAL DIRECTOR NAME: Gerald N. Minnich ADDRESS: 305 N. Potomac Street Hagerstown, Maryland			25a. DATE REC'D. BY REGISTRAR: FEB 27 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

07/84 25M

BP 1384 DHMH -17 (VR A15 ME (5))

023626 FEB 2 3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06139
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail the remaining carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: FRANCES Middle: Elizabeth Last: McGAUHEY		2a. DATE OF DEATH Month/Day/Year: 2/6/89	2b. HOUR: 7:40P M
3. SEX: female	4. RACE: white	5. DATE OF BIRTH Month/Day/Year: October 1, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Kansas	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Western Maryland Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): nurse	12b. KIND OF BUSINESS OR INDUSTRY: clinic

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	1116 Virginia avenue 21740

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
First: William Middle: Last:	First: Elizabeth Middle: Last:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: week

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebro vascular accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (X) (this hospital) attended the deceased from 12/5, 19 88, to 2/6, 19 89, that (I) (~~XX~~ last saw the deceased alive on 2/6, 19 89, and that in (my) (~~XX~~ opinion death occurred on the date and hour and from the causes stated above, (I) (~~XX~~ did) (~~XX~~ did not) view the body after death.

22b. SIGNATURE: Lne Marie Chan, M.D. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROSE MARIE CHAN — 22e. ADDRESS: Western Maryland Center, Hagerstown MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
cremation	Feb. 7, 1989	Smithsburg Crematory	Smithsburg, Wash., Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME	415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 9 '89	Julia Davidson-Randall

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

24552 MAR -3 '89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06140
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Grace	MIDDLE: Elizabeth	LAST: Mentzer	2a. DATE OF DEATH MONTH DAY YEAR: 2-22-89	2b. HOUR: 0240 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 26, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WASHINGTON MD.	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Quiller	12b. KIND OF BUSINESS OR INDUSTRY: Silk	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Williamsport	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt.2 Doub Rd. 21795
14. FATHER'S NAME FIRST: Jesse	MIDDLE: -	LAST: Dukes	15. MOTHER'S MAIDEN NAME FIRST: Dora	MIDDLE: - LAST: Lancaster
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES): ----------	16b. SOCIAL SECURITY NO.: 219-20-1295	17. INFORMANT ADDRESS: Grace Smith (item 13 above)	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septic Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Twl.
DUE TO, OR AS A CONSEQUENCE OF (b): Cancer of Vulva — 3 mo.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-3 19 89 to 2-22 19 89, that (I) (we) last saw the deceased alive on 2-5 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles F. Hess M.D.	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-22-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles F. Hess M.D.	22e. ADDRESS: Smithsburg MD. 21783	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb.25,1989	23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Mem.Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Williamsport Washington MD
24. FUNERAL DIRECTOR NAME: Major M.Osborne	ADDRESS: Williamsport, MD 21795	25a. DATE REC'D. BY REGISTRAR: FEB 23 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Mondale

122634 FEB 14 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06141
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Wilda	MIDDLE: Marie	LAST: MESSMER	2a. DATE OF DEATH MONTH DAY YEAR: February 2, 1989	2b. HOUR: M	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: August 1, 1927	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 704 Chestnut Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): .	12b. KIND OF BUSINESS OR INDUSTRY: Home Care		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Washington	Hagerstown	YES ☒ NO ☐	704 Chestnut Street 21740

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Charles / / Banard	Betty / / Hook

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		215-20-6141	Charles R. Messmer, Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Oat Cell Carcinoma of lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this ~~hospital~~) attended the deceased from JAN 83 to 2/2 89, that (I) (we) last saw the deceased alive on 1/23 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Mary E. Money M.D.		2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Mary E. Money MD	1708 Oak Hill Ave, Hagerstown, Md 21740.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 6, 1989	Cedar Lawn Mem. Park	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 6 '89	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 12

DHMH - 16 60M 7/84
(VRA 15, 4)

24551 MAR -3 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06142
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Joseph	MIDDLE: Artenis	LAST: MILBURN	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 27 '89	2b. HOUR: 7AM M	
3. SEX: male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: April 11, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.			
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 4 Downsville Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): assembler	12b. KIND OF BUSINESS OR INDUSTRY: Pangborn			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Washington	Hagerstown	YES [X] NO [ ]	4 Downsville Road 21740

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: Artenis MIDDLE: LAST: Milburn	FIRST: Emma MIDDLE: LAST: Reed

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		214-08-7138	Ronald H. Milburn, Sharpsburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrythemia	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Recent Myocardial Infarct	6 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Artery Disease	yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
none		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
[ ]	none 19	--- - - - -

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	none	- - - -

22a. I certify that (I) (this hospital) attended the deceased from Dec 8 19 86 to Feb 27 19 89 that (I) (we) last saw the deceased alive on Feb 8 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
W W Lesh	MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	2-28-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William W. Lesh M.D.	411 Division Avenue Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	March 2, 1989	Rose Hill Cemeter	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 28 '89	Sheila Davidson Registrar

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

| | | |

023783 FEB 26 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06143
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use with the transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, Form 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Bertie	MIDDLE: May M.	LAST: Miller	2a. DATE OF DEATH MONTH DAY YEAR: 02-13-89	2b. HOUR: 11:56 AM	
3. SEX: Female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 08 31 1895	6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): secretary	12b. KIND OF BUSINESS OR INDUSTRY: railroad		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: Clearview Nursing Home 21740	
14. FATHER'S NAME FIRST: Albert	MIDDLE	LAST: Miller	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Jasper Elder, Hagerstown, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — many years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): acute Left Hemiplegia Cerebral Thrombosis - Cortical Atrophy

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from ____ 19 85 to 2/13/ 19 89, that (I) (~~was~~) last saw the deceased alive on 2/12/89 19 ____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (did not) view the body after death.

22b. SIGNATURE: Edward [illegible] MD	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/15/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: Feb. 16, 1989	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Greencastle, Franklin, Pa.	
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D BY REGISTRAR: FEB 15 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

Item 16b Film G6493/14/89cg

24550 MAR -3 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06144 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: George MIDDLE: Roger LAST: Mills			2a. DATE OF DEATH MONTH: 2 DAY: 26 YEAR: 89	2b. HOUR: 0930 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 1 DAY: 31 YEAR: 1918	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Store Mgr.	12b. KIND OF BUSINESS OR INDUSTRY: Electrical	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 21 E. Lincoln Ave. 21740	
14. FATHER'S NAME FIRST: George MIDDLE: Walter LAST: Mills			15. MOTHER'S MAIDEN NAME FIRST: Rosie MIDDLE: Jeanette LAST: Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 219-05-2947	17. INFORMANT: George W. Mills, Sr.	ADDRESS: Wmspt. MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary emboli
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Early pneumonia (2 days after surgery) CHF ASCVD renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I **certify** that (I) (this hospital) attended the deceased from 2/25 19 89 to 2/26 19 89, that (I) (we) last saw the deceased alive on 2/26 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/26/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Allen W. Holmes 22e. ADDRESS: 1610 Oak Hill Ave Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: March 1, 1989	23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Park	23d. LOCATION CITY OR TOWN: Hagerstown	COUNTY: Wash. STATE: MD
24. FUNERAL DIRECTOR NAME: Major M. Osborne ADDRESS: P.O. Box 348 Wmspt. Md 21795		25a. DATE REC'D. BY REGISTRAR: FEB 28 '89	25b. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

023782 FEB 26 89

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006145

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Leon	MIDDLE: R	LAST: Moats	2a. DATE OF DEATH MONTH: 2	DAY: 16	YEAR: 1989	2b. HOUR: 1455 M
3. SEX: Male	4. RACE: Cau.	5. DATE OF BIRTH MONTH: 4	DAY: 11	YEAR: 13	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Hagerstown, Md.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.			
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Cement Kiln Operator	12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 311 Jefferson St	21740	
14. FATHER'S NAME FIRST: Samuel	MIDDLE: E.	LAST: Moats	15. MOTHER'S MAIDEN NAME FIRST: Lula	MIDDLE: May	LAST: Cross	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-09-4503	17. INFORMANT: Mrs. Retha B. Moats,	ADDRESS: 311 Jefferson Blvd. Hagerstown, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart failure

DUE TO, OR AS A CONSEQUENCE OF (c): Atherosclerotic Heart Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): T. A. Pasha, M. D.

22e. ADDRESS: 376 Mill St. Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL: Burial	23b. DATE: 2-20-89	23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery	23d. LOCATION CITY OR TOWN: Hagerstown, COUNTY: Wash. Co., STATE: Md.	
24. FUNERAL DIRECTOR NAME: John H. Bast, Jr.	ADDRESS: Bast Funeral Home Boonsboro, Md. 21713	25a. DATE REC'D. BY REGISTRAR: FEB 17 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

BP 5.

DHMH - 16 50M 1/81 (VRA 15, 4)

024549 MAR 1-3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 061456
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST					2a. DATE OF DEATH KNOWN / ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
	Donald	Willard	MOORE					XX	Feb.	23	1989	2:00 a M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
		MONTH	DAY YEAR		MONTHS	DAYS	HOURS	MIN					
male	white	June	13, 1932	56 YRS.						Feb.	23	1989	7:30 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	USA	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Washington MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Washington County Hospital	night auditor	hotel

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☐ NO ☒	37 Valley Drive 21740

14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	
William	Moore	Pearl	Robey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	1951-1955	217-28-9137	Mary C. Moore, Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	#427 - Cardiac Arrest	Immed.
DUE TO, OR AS A CONSEQUENCE OF (b)	#429 - Arteriosclerotic Cardiovascular Disease	Several Years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Edward W. Ditto M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED Feb. 24, 1989

EXAMINER'S NAME (TYPE OR PRINT) Edward W. Ditto, III, M.D. ADDRESS 217 West Washington Street Hagerstown, Maryland 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
burial	FEB 27, 1989	Rocky Gap Veterans Cem.	Flintstone, Allegany, Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS	MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D. BY REGISTRAR	FEB 24 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP 8

DHMH - 17
(VR A15 ME (5))
15M 7/77

2631 FEB 14 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06147
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Modena	MIDDLE: Estelle	LAST: MOORE	2a. DATE OF DEATH MONTH DAY YEAR: February 3, 1989	2b. HOUR: 9:30 AM
3. SEX: Female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: September 26, 1908	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 305 South Mulberry Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY: retail store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Washington	Hagerstown	YES ☒ NO ☐	305 South Mulberry Street 21740

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Lenuel / / Fish	Florence / G. / Ward

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	214-09-7355	Mrs. Shirley Wagner, Pasedena, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Apparent heart attack — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: instant.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Harold R. Tritch, Jr. MD	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Harold R. Tritch, Jr., MD	348 Mill St. Hagerstown, MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 7, 1989	Rest Haven Cemetery	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740	FEB 6 '89	Julia Davidson Randall

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

022633 FEB 14 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 061483
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH / ESTIMATED	2b. HOUR
GARY	Lynn	MOSER, II	Feb 4 1989	3:50 PM

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
M	W	Feb. 22, 1987	1 YRS.			Feb 4 1989	3:55 PM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	NEVER MARRIED	Washington MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Smithsburg	Washington Court	n/a	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Smithsburg	YES ☐ NO ☐	C-2 Washington Court 21783

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Gary	Lynn	Moser	Deborah		Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	217-13-3980	Mrs. Deborah Moser, Smithsburg, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

8147

IMMEDIATE CAUSE (a) Severe Head injury — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	3 P.M. Feb 4 1989	Hit by VAN

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Street	WASHINGTON COURT Smithsburg Wash MD.

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Howard N. Weeks M.D. TITLE (SPECIFY) DP MEDICAL EXAMINER DATE SIGNED Feb 4, 89

EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks ADDRESS 550 Northern Av Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 7, 1989	Cedar Lawn Mem. Park	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740	FEB 6 '89	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 5

DHMH - 17 (VR A15 ME (5))

024548 MAR 13 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06149
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Pauline MIDDLE Alberta LAST Mowen

2a. DATE OF DEATH: MONTH 2 DAY 20 YEAR 89 — 2b. HOUR 12 M

3. SEX: female

4. RACE: white

5. DATE OF BIRTH: MONTH March DAY 4 YEAR 1910

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Washington — 13c. CITY OR TOWN: Hagerstown — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 314 West Side Avenue 21740

14. FATHER'S NAME: FIRST unknown MIDDLE LAST Buchanon

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE Julia LAST Trumpower

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 220-16-1356

17. INFORMANT ADDRESS: Calvin Mowen, Hagerstown, Md.
Irma Young, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (mo)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Obstructive Pulmonary Disease — 4 yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from ____, 19____, to 2-20, 19 89, that (I) (we) last saw the deceased alive on 2-20 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-21-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT):

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial

23b. DATE: Feb. 23, 1989

23c. NAME OF CEMETERY OR CREMATORY: Broadfording Mem. Gardens

23d. LOCATION: CITY OR TOWN Hagerstown COUNTY Wash. STATE Md.

24. FUNERAL DIRECTOR: NAME MINNICH FUNERAL HOME
ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740

25a. DATE REC'D. BY REGISTRAR: FEB 22 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

0245 20 MAR -3 89

18-87-

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 06150
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Gerald — MIDDLE: Daniel D — LAST: Nye

2a. DATE OF DEATH — MONTH DAY YEAR: 2-27-89

2b. HOUR: 4A M

3. SEX: male

4. RACE: white

5. DATE OF BIRTH — MONTH DAY YEAR: August 22, 1922

6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retail sales

12b. KIND OF BUSINESS OR INDUSTRY: country club

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 533 Maryland Avenue 21740

14. FATHER'S NAME — FIRST: Elmer — MIDDLE: N. — LAST: Nye

15. MOTHER'S MAIDEN NAME — FIRST: Elsie — MIDDLE: M. — LAST: Beam

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): W.W.II

16b. SOCIAL SECURITY NO.: 217-12-1643

17. INFORMANT — ADDRESS: J. Michael Nye, Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Anoxic encephalopathy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 16 days

DUE TO, OR AS A CONSEQUENCE OF (b): Cardiac arrest — 16 days

DUE TO, OR AS A CONSEQUENCE OF (c): Acute myocardial infarction — 16 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from July, 19 88, to Feb 27, 19 89, that (I) (we) last saw the deceased alive on 2/25, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.

22b. SIGNATURE AND DEGREE: Richard E. Smith, M.D. — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Richard E. Smith, M.D.

22e. ADDRESS: 1708 Oak Hill Ave, Hagerstown Md 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial

23b. DATE: March 1, 1989

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION — CITY OR TOWN, COUNTY, STATE: Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR (NAME, ADDRESS): MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740

25a. DATE REC'D BY REGISTRAR: FEB 28 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Bundard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

22635 FEB 14 8

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06151
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JAMES / WILLIAM / PETERS	2a. DATE OF DEATH MONTH DAY YEAR	FEB 4 89	2b. HOUR	1:25 PM
3. SEX	male	4. RACE	white	5. DATE OF BIRTH MONTH DAY YEAR	April 21, 1899
6. AGE (IN YEARS LAST BIRTHDAY)	89 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	WASHINGTON COUNTY MD.				
10. CITY OR TOWN OF DEATH	HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	AVALON MANOR.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	plumber
12b. KIND OF BUSINESS OR INDUSTRY	aircraft				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Washington	13c. CITY OR TOWN	Hagerstown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS	328 Avon Road 21740		
14. FATHER'S NAME FIRST / MIDDLE / LAST	William H. Peters	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Laura Kepley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	yes	(IF YES, GIVE WAR OR DATES)	W.W.I	16b. SOCIAL SECURITY NO.	214-09-2050
17. INFORMANT ADDRESS	Mrs. Clara M. Peters, Hagerstown, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure / Renal Insufficiency	Few days
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Heart Disease / Glomerulonephritis	
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis, Generalized	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2 Dec 87 to 4 Feb 89, that (I) (we) last saw the deceased alive on Feb 2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	W. N. Feuder	DEGREE	M.D.
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒		22c. DATE SIGNED	6 Feb. 1989
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	W. N. Feuder	22e. ADDRESS	138 E. Antietam St. Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	burial	23b. DATE	Feb. 8, 1989	23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME / ADDRESS	MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D. BY REGISTRAR	FEB 6 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

022958 FEB 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 061522

1. DECEASED NAME (TYPE OR PRINT): FIRST ADA MIDDLE Belle LAST PLESSINGER

2a. DATE OF DEATH: MONTH February DAY 7 YEAR 1989

2b. HOUR: M

3. SEX: female

4. RACE: Caucasian

5. DATE OF BIRTH: MONTH May DAY 06 YEAR 1900

6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington, MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Pennsylvania 13b. COUNTY: Fulton 13c. CITY OR TOWN: Warfordsburg 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS: Rt.2 Box 1420 17267

14. FATHER'S NAME: FIRST Alvin MIDDLE Blair LAST Hurley

15. MOTHER'S MAIDEN NAME: FIRST Emma MIDDLE E. LAST Carpenter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 161-50-3731

17. INFORMANT: Belva E. Schriever ADDRESS: Rt.2 Box 1720 Warfordsburg, Pa. 17267

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hrs.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic cardiovascular disease yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cholangiocarcinoma

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 89 to 2/7 19 89 that (I) (we) last saw the deceased alive on 2/6 19 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Charles R Chaney DEGREE: M2 ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles R. Chaney M.D.

22e. ADDRESS: 363 S. Cleveland Ave. Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 02/11/89

23c. NAME OF CEMETERY OR CREMATORY: Jerusalem Christian

23d. LOCATION: CITY OR TOWN Warfordsburg, COUNTY Fulton, STATE Penna.

24. FUNERAL DIRECTOR NAME: [illegible] ADDRESS: 141 W. Main St. Hancock, Md. 21750

25a. DATE REC'D. BY REGISTRAR: FEB 13 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

022637 FEB 14 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06153 — REG. NO

1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last: John R Poffenberger			2a. DATE OF DEATH Month Day Year: 2/2/89	2b. HOUR: 12:40Am	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: Sept. 5, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Hagerstown, Md.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WASHINGTON County MD		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrician	12b. KIND OF BUSINESS OR INDUSTRY: Furniture Mfg.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Washington	Boonsboro	YES ☐ NO ☒	Rfd. 1 Box 33	21713

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	
Thomas A. Poffenberger	Annie Belle Murray	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-09-1831	William T. Poffenberger,	590 W. Oak Ridge Ave. Hagerstown, Md. 21740

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Septicemia

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabeter mellitus, Congestive heart failure, transitional cell carcinoma of bladder

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1-17-89	Transitional cell carcinoma of bladder	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 1-10 19 89 to 2-2 19 89, that (I) ~~(we)~~ last saw the deceased alive on 2-2 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Charles R. Spencer	M.D.	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	2-2-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Charles R. Spencer	1198 Henly Ave Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-4-89	Benevola Cemetery	Benevola, Wash. Co., Md.

24. FUNERAL DIRECTOR NAME	ADDRESS		25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John H. Bast, Jr.	Bast Funeral Home Boonsboro, Md.	21713	FEB 3 '89	Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

024545 MAR - 3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06154

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Elmer	MIDDLE: W	LAST: Poole	2a. DATE OF DEATH MONTH DAY YEAR: February 25 1989	2b. HOUR: 7:40 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: APRIL 12 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Clear Spring MD	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.	
10. CITY OR TOWN OF DEATH: Williamsport md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Williamsport Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK DONE FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY: Moller Organ Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 55 E. Washington St. 21740
14. FATHER'S NAME FIRST: John	MIDDLE: William	LAST: Poole	15. MOTHER'S MAIDEN NAME FIRST: Jennie	MIDDLE: V. LAST: Repp
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 216-01-3069	17. INFORMANT: Julia F. Poole	ADDRESS: 55 E. Washington St Hagerstown MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Aspirative Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from July 29, 19 85 to February 25 89, that (I) (we) last saw the deceased alive on February 28 89, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ted Howe MD	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [X]	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): TED E. HOWE	22e. ADDRESS: CUMBERLAND, MARYLAND	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-28-89	23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetary	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Clear Spring Wash. MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: Thompson Funeral Home Inc. Clear Spring MD	25a. DATE REC'D. BY REGISTRAR: FEB 28 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall		

BP 7

DHMH - 16 60M 7/84
(VRA 15, 4)

023781 FEB

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 06155 REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Joseph	MIDDLE: Clinton	LAST: PRESGRAVES	2a. DATE KNOWN OF DEATH / ESTIMATED: MONTH 2 DAY 15 YEAR 89	2b. HOUR 1705 M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH April DAY 26, YEAR 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 15 YEAR 89	2d. HOUR 1705 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD			
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Water Plant			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Wash.	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS: 318 Mealey Parkway 21740		
14. FATHER'S NAME FIRST: William	MIDDLE: E.	LAST: Presgraves	15. MOTHER'S MAIDEN NAME FIRST: Winnie	MIDDLE	LAST: Davis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 217-12-1381	17. INFORMANT: Gloria V. Presgraves	ADDRESS: Hagerstown, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic obstructive lung disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Dep Asst MEDICAL EXAMINER DATE SIGNED: 2/15/89

EXAMINER'S NAME (TYPE OR PRINT): Allan D. Ditto MD ADDRESS: 1610 Oak Hill Ave Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Feb. 17, 1989	23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Smithsburg, Wash, Md.
24. FUNERAL DIRECTOR NAME: Davis Funeral Home	ADDRESS: Smithsburg, Md.	25a. DATE REC'D BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

024544 MAR -3 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06156
REG. NO

FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Ronald	Middle: E	Last: Redman	2a. DATE OF DEATH Month Day Year: 2-26-89	2b. HOUR: 2149 M	
3. SEX: MALE	4. RACE: Caucasian	5. DATE OF BIRTH Month Day Year: 01 22 27	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Rohrersville, Md.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington	MD.	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Welder	12b. KIND OF BUSINESS OR INDUSTRY: Railroad Co.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Rohrersville	YES ☐ NO ☒ X	Rfd. 1 Box 24 21779

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	Allen	Redman	Thelma	Mae	Holler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS
Yes	W. W.Two 216-22-9064	Billiy Redman,	503 Chestnut St. Hagerstown, Md. 21740

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Aorta
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 86, 19____, to ____, 19____, that (I) (we) last saw the deceased alive on ____, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
R.L. Kugler	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
R.L. Kugler MD	Geeting Ln Keedysville, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	3-1-89	Brownsville Hgts. Cem.	Brownsville, Wash. Co., Md.

24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John H. Bast, Jr.	Bast Funeral Home Boonsboro, Md. 21713	FEB 28 89	

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

22625 FEB 14 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06157
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Milo	Andrew	RIDENOUR	February 5, 1989	10:00 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	April 4, 1903	85 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Mt. Lena, Md.	U. S. A.		Washington		MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Boonsboro	Rfd 2 Box 195	Heat Treating Operator, Mfg.	Aircraft		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Boonsboro	YES ☐ NO ☒	Rfd. 2 Box 195 21713

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
David	Martin	Ridenour	Minnie	May	Bowman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-09-3287	Earl C. Ridenour,	Rfd. 2 Box 195 Boonsboro, Md. 21713

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Cardiac Arrythemia	6 mos
DUE TO, OR AS A CONSEQUENCE OF (c)	V Coronary Artery Disease	yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Organic Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
none	-	YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
	none 19	- - - -

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	none	-	-	-	-

22a. I certify that (I) (this hospital) attended the deceased from 4/17, 19 72, to 2/5/, 19 89, that (I) (we) last saw the deceased alive on 11/28/, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
W W Lesh MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-6-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William W. Lesh M.D.	411 Division Ave Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN, COUNTY, STATE
Burial	2-8-89	Beaver Creek Cemetery	Beaver Creek, Wash. Co., Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John H. Bast, Jr.	Bast Funeral Home Boonsboro, Md. 21713	FEB 07 '89	Julia Davidson-Rondelle

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

022624 FEB 14 09

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06153
REG. NO

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Irene — MIDDLE: F — LAST: Ruppenthall

2a. DATE OF DEATH — MONTH DAY YEAR: 2-5-89

2b. HOUR: 1600 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY, YEAR: Dec. 6, 1917

6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Boonsboro, Md.

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Boonsboro

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: Rfd. 3 Box 395 21713

14. FATHER'S NAME — FIRST: Josiah — MIDDLE: Earl — LAST: Itnyre

15. MOTHER'S MAIDEN NAME — FIRST: Elsie — MIDDLE: Mae — LAST: Biser

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 212-78-7927

17. INFORMANT — ADDRESS: Mr. Melvin C. Ruppenthall, Rfd. 3 Box 395 Boonsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Sepsis Shock
DUE TO, OR AS A CONSEQUENCE OF (c): Renal Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Hypertension

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 4 19 89 to 2/5 19 89, that (I) (we) last saw the deceased alive on 2/5 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Sidney Rovenstein — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): SIDNEY ROVENSTEIN

22e. ADDRESS: HAGERSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2-6-89

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory

23d. LOCATION — CITY OR TOWN / COUNTY / STATE: Smithsburg, Wash. Co., Md.

24. FUNERAL DIRECTOR — NAME / ADDRESS: Bast Funeral Home, John H. Bast, Jr. Boonsboro, Md. 21713

25a. DATE REC'D. BY REGISTRAR: FEB 07 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

022622 FEB 14 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

Donald Sanders

REG. NO. 89 06159

1. DECEASED NAME (TYPE OR PRINT): First Donald, Middle G, Last Sanders

2a. DATE OF DEATH: Month 2, Day 6, Year 89

2b. HOUR: 657 AM

3. SEX: M

4. RACE: White

5. DATE OF BIRTH: Month 7, Day 30, Year 37

6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver

12b. KIND OF BUSINESS OR INDUSTRY: Transport Vehicle

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Boonsboro

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: Rt. 4 Box K9 21713

14. FATHER'S NAME: First Bernard, Middle Washington, Last Sanders

15. MOTHER'S MAIDEN NAME: First Lena, Middle Marie, Last Wiles

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 209-28-9241

17. INFORMANT: Arlene H. Sanders

ADDRESS: Route 4 Boonsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RESPIRATORY FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONIA — BLASTOMYCOSIS

DUE TO, OR AS A CONSEQUENCE OF (c): DIABETES MELLITUS I.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART IIa.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1.16 19 89 to 2.6 19 89 that (I) (we) last saw the deceased alive on 2.5 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Otto Roza

DEGREE: MD

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2.6.89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): OTTO ROZA MD

22e. ADDRESS: 100 LONG MEADOW DRIVE HAGERSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 2/7/89

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory

23d. LOCATION: CITY OR TOWN Smithsburg, COUNTY Washington, STATE Md.

24. FUNERAL DIRECTOR NAME: Gerald N. Minnich

ADDRESS: 305 N. Potomac Street Hagerstown, Maryland

25a. DATE REC'D. BY REGISTRAR: 2-13-89

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

022623 FEB 14 89 P

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06160
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Agnes MIDDLE:	LAST: Sayles	2a. DATE OF DEATH MONTH: 2 DAY: 3 YEAR: 89	2b. HOUR: 3:05 AM	
3. SEX: Female	4. RACE: Cauca	5. DATE OF BIRTH MONTH: 7 DAY: 16 YEAR: 98	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Cotton Villa	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hagerstown	YES ☒ NO ☐	7 E. Washington Street 21740

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
George W. Drill	Mary St. Clair	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	219-12-1769	A. Richard Sayles	640 Pin Oak Dr. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest-
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular accident-
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Abdul	☐ ☒ ☐	2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ABDUL WAHEED, MD	1610 OAK HILL AVE. Hagerstown. MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/6/89	Rose Hill Cemetery	Hagerstown Wash., Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gerald N. Minnich	305 N. Potomac Street Hagerstown, Maryland	FEB 7 '89	Julia Davidson Rondelle

0238282 FEB 2 8 89

25-38

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 06161

1. DECEASED NAME (TYPE OR PRINT) FIRST: Paul	MIDDLE: Raymond	LAST: Schaffer	2a. DATE OF DEATH MONTH: 2 DAY: 6 YEAR: 89	2b. HOUR: 11:40 P M	
3. SEX: Male	4. RACE: Cauc	5. DATE OF BIRTH MONTH DAY YEAR: December 17, 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): sheet metal	12b. KIND OF BUSINESS OR INDUSTRY: aircraft		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Williamsport	YES ☐ NO ☐	2450 Virginia Avenue 21795

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
James	William	Schaffer	Sara	M.	Anderson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		214-09-9206	Helen E. Schaffer	Williamsport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage Bradistoc — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Carcinoma of Colon (Rectum) Adenocarcinoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (~~His~~ hospital) attended the deceased from _____, 19 80, to 2-6, 19 89, that (I) (~~we~~) last saw the deceased alive on 2-6, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M E Byrkit	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-8-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
M E Byrkit	Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	Feb. 9, 1989	Rose Hill Cemetery	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME	415 E. Wilson Blvd., Hagerstown, Md. 21740	FEB 9 '89	Phoebe Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 8

DHMH - 1650M 1/81 (VRA 15, 4)

0231 60 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 005 106 2

1. DECEASED NAME (TYPE OR PRINT) FIRST: Carl	MIDDLE: W	LAST: Sheffield	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 6, 1989	2b. HOUR: 3 A. M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 28, 1930	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington Co., MD.			
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Co. Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Army Depot	12b. KIND OF BUSINESS OR INDUSTRY: Nat. Def.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pa.	13b. COUNTY: Franklin	13c. CITY OR TOWN: Mercersburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 10647 Claylick Rd Mercersburg, Pa. 17236		
14. FATHER'S NAME FIRST: Lester	MIDDLE	LAST: Sheffield	15. MOTHER'S MAIDEN NAME FIRST: Annie	MIDDLE	LAST: Kerlin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 186-24-7888	17. INFORMANT: Gloria Sheffield	ADDRESS: 10647 Claylick Rd. Mercersburg, Pa. 17236		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIO-RESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): STUPOR METABOLIC + RESPIRATORY ACIDOSIS

DUE TO, OR AS A CONSEQUENCE OF (c): PNEUMONIA RIGHT LUNG

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): AMYLOIDOSIS. BRONCHIECTASIS. RENAL FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from September 19 88, to 2-6 19 89, that (I) (we) last saw the deceased alive on 2-6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2.6.89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): OTTO ROZA MD	22e. ADDRESS: 100 LONG MEADOW DRIVE HAGERSTOWN MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/9/89	23c. NAME OF CEMETERY OR CREMATORY: Parklawnd Mem. Gard.	23d. LOCATION CITY OR TOWN: Greene Twp., COUNTY: Franklin STATE: Pa	
24. FUNERAL DIRECTOR NAME: [signature]	ADDRESS: Mercersburg, Pa. 17236	25a. DATE REC'D BY REGISTRAR: FEB 13 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

024543 MAR - 89

FOR 1 - STATE REGISTRAR

REG. NO. 89 06163

1. DECEASED NAME (TYPE OR PRINT): FIRST Ruth MIDDLE Ellen LAST SINES

2a. DATE OF DEATH: MONTH 2 DAY 22 YEAR 89

2b. HOUR 3:35 AM

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH Feb. DAY 4 YEAR 1909

6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.

10. CITY OR TOWN OF DEATH: Williamsport

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Williamsport Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 832 Lanvale Street 21740

14. FATHER'S NAME: FIRST John MIDDLE E. LAST Zombro

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE L LAST Daymude

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No IF YES, GIVE WAR OR DATES:

16b. SOCIAL SECURITY NO.: 214-24-3140

17. INFORMANT: Terry L. Sines ADDRESS: Rt. 4 Box 36 A Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to 2-22 19 89, that (I) (we) last saw the deceased alive on 2-13 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ted Howe. MD DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 2-22-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): TED E. HOWE.

22e. ADDRESS: OLNEY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/24/89

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION CITY OR TOWN: Hagerstown COUNTY: Washington STATE: Md.

24. FUNERAL DIRECTOR NAME: Gerald N. Minnich ADDRESS: 305 N. Potomac Street Hagerstown, Maryland

25a. DATE REC'D BY REGISTRAR: FEB 23 '89

25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Statement permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 16 60M 7/84
(VRA 15, 4)

023627 FEB

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 061644

DIVISION OF VITAL RECORDS, 2D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining carbon papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dorothy	MIDDLE: Catherine	LAST: SLADE	2a. DATE OF DEATH MONTH DAY YEAR: February 6, 1989	2b. HOUR: M
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: December 14, 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 55 E. Washington Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): industrial nurse	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 55 E. Washington St. 313 21740
14. FATHER'S NAME FIRST: Gordon	MIDDLE	LAST: Roberson	15. MOTHER'S MAIDEN NAME FIRST: Emma	MIDDLE	LAST: Veil
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-26-1807	17. INFORMANT ADDRESS: Sandra Damasiewicz, Hagerstown, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerotic Coronary Vascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Chronic obstructive pulmonary disease. Carotid Vascular Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dmt. Dale	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/7/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DIMO J. DECAPOTAS MD	22e. ADDRESS: 783 OAK HILL AVE, HAGERSTOWN MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): cremation	23b. DATE: Feb. 7, 1989	23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Smithsburg, Wash., Maryland
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsell

BP 4

DHMH - 16 60M 7/84
(VRA 15, 4)

B23633 FEB 23 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06165

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 20

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: Grace	LAST: SMITH	2a. DATE OF DEATH MONTH DAY YEAR: February 10, 1989
2b. HOUR: M			
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: December 20, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Colton Villa Nursing Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 1601 Oak Hill Avenue 21740			
14. FATHER'S NAME FIRST: William	MIDDLE: E.	LAST: Rupp	15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE: LAST: Kagle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-14-6998	17. INFORMANT ADDRESS: Doris Long, Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/10/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABDUL WAHEED, MD	22e. ADDRESS: 1610 OAK HILL AVE. HAGERSTOWN MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: Feb. 13, 1989	23c. NAME OF CEMETERY OR CREMATORY: Pike Creek Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Union Bridge, Carroll, Md.
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D. BY REGISTRAR: FEB 14 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024211 FEB 20 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06166 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Richard MIDDLE: Willard LAST: SMITH			2a. DATE OF DEATH MONTH DAY YEAR: 2 12 89	2b. HOUR: 0655 M
3. SEX: male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 5, 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: WASHINGTON MD.	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): mud mixer	12b. KIND OF BUSINESS OR INDUSTRY: construction
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: Hager Hotel 21740
14. FATHER'S NAME FIRST: Cecil MIDDLE: Baker LAST: Smith			15. MOTHER'S MAIDEN NAME FIRST: Lillian MIDDLE: LAST: Semler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 219-05-2107	17. INFORMANT ADDRESS: Benson M. Smith, Hagerstown, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): cardio pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b): pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1988 19____ to ____ 19____, that (I) (we) last saw the deceased alive on 2-11-89 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 2-12-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Feb.13,1989	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D BY REGISTRAR: FEB 20 1989	25b. REGISTRAR'S SIGNATURE: Julia Feidler-Lindsay

23637 FEB 23 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 006167

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH	DAY	YEAR	2b. HOUR
STEVEN	LEE	SMITH	Feb	13	1989	A M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
M	W	May 4 51	37 YRS.			Feb 13 1989	5:40 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Washington MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Keedysville	Washington County Hospital	Mack Trucks	Esembler

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS
Maryland	Washington	Sharpsburg		16815 Taylors Landing Rd. 21782

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	Reno	Smith	Viola	Etta	Horning

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		212-58-9906	Marilyn Smith 16815 Taylors Landing Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	gun shot wound Through A Woman	SUDDEN
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	Feb 13 1989	

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	field	Rt 34 nr Porterstown Rd / WASH / MD

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE H. N. Weeks TITLE (SPECIFY) M.D. DeP MEDICAL EXAMINER DATE SIGNED Feb 13 '89

EXAMINER'S NAME (TYPE OR PRINT) H. N. Weeks ADDRESS 380 Northern Av Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	Feb.17,1989	Cedar Lawn Mem. Park	Hagerstown	Wash,. MD

24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Major M. Osborne PO Box 348 Williamsport,Md	21795	FEB 14 '89	Julia Davidson-Randall

07/84 25M BP 5

DHMH - 17 (VR A15 ME (5))

24584 MAR -3 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06168
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP 15

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Kenneth	MIDDLE: Stanley	LAST: Snapp	2a. DATE OF DEATH MONTH DAY YEAR: Feb 25 89	2b. HOUR: 1:20 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 2 28 1920	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY: aircraft		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 912 Mulberry Avenue	21740
14. FATHER'S NAME FIRST: Hollis	MIDDLE: E.	LAST: Snapp	15. MOTHER'S MAIDEN NAME FIRST: Dora	MIDDLE	LAST: Bixler
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220-10-3067	17. INFORMANT ADDRESS: Mrs. Dorothy E. Snapp, Hagerstown, MD.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Oat Cell Cancer of left lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one year

DUE TO, OR AS A CONSEQUENCE OF (b): Cigarettes — 50 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Asthma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/16, 19 89, to 2/25, 19 89, that (I) (we) last saw the deceased alive on 2/25, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Brull	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/25/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert Brull	22e. ADDRESS: 1459 Potomac Ave. Hagerstown		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: March 1, 1989	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR NAME: MINNICH FUNERAL HOME ADDRESS: 415 East Wilson Blvd., Hagerstown, Maryland 21740	25a. DATE RECD. BY REGISTRAR: FEB 28 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024583 MAR -3 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06169 REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT): FIRST Stella MIDDLE E LAST Spigler
2a. DATE OF DEATH: MONTH Feb. DAY 27 YEAR 89
2b. HOUR: 2:01 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 03 DAY 02 YEAR 1906
6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Washington Co. MD.
10. CITY OR TOWN OF DEATH: Hagerstown
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Co. Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Washington
13c. CITY OR TOWN: Hagerstown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 1655 Frederick St. 21740

14. FATHER'S NAME: FIRST George MIDDLE LAST Blair
15. MOTHER'S MAIDEN NAME: FIRST Mamie MIDDLE LAST Sword
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): NO
16b. SOCIAL SECURITY NO.: 214-09-5749
17. INFORMANT: Dorothy Gruber ADDRESS: 3N. Artizan St. Williamsport, MD 21795

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Carcinoma, lung, Cystitis Heart failure

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from June 1982 to Feb. 1989, that (I) (we) last saw the deceased alive on 2/26 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Gloria F Pura DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/27/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): GLORIA F. PURA
22e. ADDRESS: 366 MILL ST. HAGERSTOWN

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 3-2-1989
23c. NAME OF CEMETERY OR CREMATORY: Blairsville Cem.
23d. LOCATION CITY OR TOWN: Clearspring COUNTY: Wash. STATE: MD
24. FUNERAL DIRECTOR NAME: Thompson Funeral Home Inc. ADDRESS: Clearspring MD
25a. DATE REC'D. BY REGISTRAR: FEB 28 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson

023622 FEB 23 89

FOR STATE REGISTRAR RUTH MIDDLEKAUFF STINE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06170
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First / Middle / Last	Ruth Middle Kauff STINE
2a. DATE OF DEATH Month / Day / Year	2 6 89
2b. HOUR	7:20 PM
3. SEX	Female
4. RACE	White
5. DATE OF BIRTH Month / Day / Year	August 19, 1894
6. AGE (IN YEARS LAST BIRTHDAY)	94 YRS
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Washington Co., MD.
10. CITY OR TOWN OF DEATH	Hagerstown
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Avalon Manor Nsg. Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker
12b. KIND OF BUSINESS OR INDUSTRY	Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland
13b. COUNTY	Washington
13c. CITY OR TOWN	Hagerstown
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET ADDRESS	1666 Fountain Head Road 21740
14. FATHER'S NAME First / Middle / Last	William Lycurgus Middlekauff
15. MOTHER'S MAIDEN NAME First / Middle / Last	Emma Myriah Mullen
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No
(IF YES, GIVE WAR OR DATES)	- - -
16b. SOCIAL SECURITY NO.	214-09-5985
17. INFORMANT	Doris S. Bennett
ADDRESS	1666 Fountain Head Road Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3 hours

DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Coronary Vessel disease — 15 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8/25 19 88 to 2/6 19 89, that (I) (we) last saw the deceased alive on 1/31 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Robert Brull	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED	2/6/89		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Robert Brull	22e. ADDRESS	1459 Potomac Ave. Hagerstown

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2-9-89	Rest Haven Cemetery	Hagerstown, Washington, Md.	
24. FUNERAL DIRECTOR NAME	ADDRESS	25. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman Funeral Home, Inc.	Hagerstown, Md.	FEB 9 '89	Julia Davidson-Randall	

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

023623 FEB 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR STATE REGISTRAR ALFRED LEON STOTELMYER CERTIFICATE OF DEATH
89 06171
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ALFRED	LEON	STOTELMYER	2a. DATE OF DEATH MONTH DAY YEAR	2-5-89
				2b. HOUR	10:07 AM
3. SEX	Male				
4. RACE	White				
5. DATE OF BIRTH MONTH DAY YEAR	September 6, 1930				
6. AGE (IN YEARS LAST BIRTHDAY)	58 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland				
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.				
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]					
9. BALTIMORE CITY OR COUNTY OF DEATH	Washington County MD.				
10. CITY OR TOWN OF DEATH	Hagerstown				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Washington County Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Laborer				
12b. KIND OF BUSINESS OR INDUSTRY	City of Hagerstown				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland				
13b. COUNTY	Washington				
13c. CITY OR TOWN	Hagerstown				
13d. INSIDE CITY LIMITS? YES [X] NO [ ]					
13e. STREET ADDRESS	407 West Antietam Street				21740
14. FATHER'S NAME FIRST / MIDDLE / LAST	Lewis	Victor	Stotelmyer		
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Catherine	Elizabeth	Rohrer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No				
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	215-26-8932	- - -			
17. INFORMANT ADDRESS	Harriet E. Stotelmyer 407 West Antietam Str Hagerstown, Md.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (c) Recent Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED 2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. A. PASHA M.D.
22e. ADDRESS 376 - MILL ST. HAGERSTOWN MD 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2-8-89	Cedar Lawn Memorial Pk.	Hagerstown, Washington, Md.	
24. FUNERAL DIRECTOR NAME / ADDRESS	Andrew K. Coffman Funeral Home, Inc.	Hagerstown, Md.	25a. DATE REC'D. BY REGISTRAR	FEB 9 '89
25b. REGISTRAR'S SIGNATURE	Gisha Davidson-Randall			

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023467 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 061 72

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Helen	Irene	Stotlemeyer

2a. DATE OF DEATH: February 16, 1989 | 2b. HOUR: 1:35P.M

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	White	October 3, 1902	86 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	USA		Washington, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Western Maryland Center	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Washington	Hancock	YES ☐ NO ☒	Rt.2 21750

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
William M. Heasley	Brown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (NAME, ADDRESS)
No		217-42-7683	Ronald J.Cunningham 30709 Avondale Westland,Mich. 48185

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia and Pulmonary Edema	Feb. 7, 1989
DUE TO, OR AS A CONSEQUENCE OF (b)	Brain Tumor	Sept., 1988
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY (HOUR A.M./P.M. MONTH DAY YEAR 19)	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE)
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (X) this hospital) attended the deceased from Jan. 6, 19 88, to Feb. 16, 19 89, that (I) (X) last saw the deceased alive on Feb. 16, 19 89, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XX) (did) (XXXX) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Fe U. Porciuncula	M. D.	☐ / ☐ / ☒	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Fe U. Porciuncula, M. D.	1500 Pennsylvania Avenue Hagerstown, Maryland 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN, COUNTY, STATE)
Burial	02/20/89	Hancock Presbyterian	Hancock, Washington, Maryland

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[illegible]	141W.Main St.Hancock,Md. 21750	FEB 21 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023780 FEB 25

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 9 6 1 7 3

1. DECEASED NAME (TYPE OR PRINT): First Charles Middle William Last Stump
2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month 2 Day 14 Year 1989
2b. HOUR 02 AM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Month Sept. Day 15, Year 1928
6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: Month 2 Day 14 Year 1989
2d. HOUR 02 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Shepherdstown, W. Va.
7b. CITIZEN OF WHAT COUNTRY? U. S. A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD
10. CITY OR TOWN OF DEATH: Hagerstown
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor, County Land Fill Dept.
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Washington
13c. CITY OR TOWN: Keedysville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 30 North Main St. 21756

14. FATHER'S NAME: First Charles Middle O. Last Stump
15. MOTHER'S MAIDEN NAME: First Roslie Middle [illegible] Griffith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 1-25-46 7-24-47
16b. SOCIAL SECURITY NO.: 213- 24- 9951
17. INFORMANT'S NAME, ADDRESS: Patricia ~~Peggy~~ Steele, 30 N. Main St. Keedysville, Md. 21756

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Diabetes mellitus, Hypertension Tobacco abuse

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Dep't Asst MEDICAL EXAMINER DATE SIGNED 2/14/89

EXAMINER'S NAME (TYPE OR PRINT) Allen W. Dietz M.D. ADDRESS 1610 Oak Hill Ave. Hagerstown MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-17-89
23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
23d. LOCATION CITY OR TOWN Keedysville COUNTY Wash. Co. STATE Md.
24. FUNERAL DIRECTOR NAME: John H. Bast, Jr. Bast Funeral Home Boonsboro, Md. 21713
25a. DATE REC'D. BY REGISTRAR: FEB 16 '89
25b. REGISTRAR'S SIGNATURE: Lydia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 8

DHMH - 17 (VR A15 ME (5))

023596 FEB 23 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06174
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Harold	Middle: L	Last: Thomas	2a. DATE OF DEATH Month Day Year: 2-10-89	2b. HOUR: 3:30 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: 3 13 39	6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington Co., MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Assembly Line	12b. KIND OF BUSINESS OR INDUSTRY: Crane Mfg.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
PA.	Franklin	Mercersburg	YES ☐ NO ☒	3483 Mountain Rd

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
Lewis E. Thomas	Eva Dorty	No	209-28-7772	Norma J. Thomas, 3483 Mountain Rd. Mercersburg, Pa. 17236

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST — Approximate interval between onset and death:
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): POLYCYSTIC KIDNEY DISEASE & CHRONIC RENAL FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 2-10 19 89 to 2-10 19 89, that (I) (we) last saw the deceased alive on 2-10 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Eli Roza	MD	☐ ☒ ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
ELI ROZA	WASHINGTON COUNTY HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/14/89	Fairview Cem.	Mercersburg Franklin Pa.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
M. Ensminger, Mercersburg, Pa. 17236	FEB 20 1989	Julia Fenton Lenhart

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024582 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06175

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Donald	MIDDLE: Eugene	LAST: TOMS	2a. DATE OF DEATH MONTH DAY YEAR: February 26, 1989	2b. HOUR: M
3. SEX: male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: June 7, 1948	6. AGE (IN YEARS LAST BIRTHDAY): 40 YRS	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD	
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1440 West Church Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): salesman	12b. KIND OF BUSINESS OR INDUSTRY: Noland Co.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Washington	Hagerstown	YES [X] NO [ ]	1440 West Church Street 21740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Bernard	L.	Toms	Marilyn		Kennedy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		220-54-3617	Mrs. Mary Ann Toms, Hagerstown, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pickwickian Syndrome — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/12 19 87 to 2/26 19 89, that (I) (we) last saw the deceased alive on 10/14 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Frederick A Kass	MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/28/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Frederick H. Kass III	1825 Howell Rd Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	March 2, 1989	Rose Hill Cemetery	Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740	FEB 28 '89	Julia Davidson Rhodes

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 006176

0226 27 FEB 1 89

1. DECEASED NAME (TYPE OR PRINT) — First: Helen; Middle: Augusta; Last: Toms

2a. DATE OF DEATH — Month: February; Day: 1; Year: 1989

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — Month: August; Day: 27; Year: 1914

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: Washington County MD.

10. CITY OR TOWN OF DEATH: Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 132 East Irvin Avenue

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Public School

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Washington

13c. CITY OR TOWN: Hagerstown

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE: 132 East Irvin Avenue 21740

14. FATHER'S NAME — First: Emmert; Middle: K.; Last: Toms

15. MOTHER'S MAIDEN NAME — First: Daisy; Middle: Mae; Last: Rowland

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): - - -

16b. SOCIAL SECURITY NO.: 253-64-2771

17. INFORMANT: Orville D. Fox

ADDRESS: 132 East Irvin Avenue, Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio-respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Stroke — 7 days

DUE TO, OR AS A CONSEQUENCE OF (c): Atheriosclerosis; Hypertension — yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: none

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M.: none; MONTH: none; DAY: none; YEAR: 19

21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): - - - -

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): none

21f. LOCATION — STREET: - ; CITY OR TOWN: - ; COUNTY: - ; STATE: -

22a. I certify that (I) (this hospital) attended the deceased from 12-17 19 86 to 2/1/89 19 ____, that (I) (we) last saw the deceased alive on Jan. 30 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William W. Lesh M.D.

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-1-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): William W. Lesh M.D.

22e. ADDRESS: 411 Division Avenue Hagerstown, Md. 21740

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-3-89

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION — CITY OR TOWN: Hagerstown; COUNTY: Washington; STATE: Md.

24. FUNERAL DIRECTOR — NAME: Andrew K. Coffman Funeral Home, Inc.; ADDRESS: Hagerstown, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 3 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

BP 10

DHMH - 16 60M 7/84
(VRA 15, 4)

23614 FEB 23 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pick remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06177
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mildred MIDDLE: L LAST: Trumpower	2a. DATE OF DEATH MONTH DAY YEAR: 2 - 6 - 1989	2b. HOUR: 1325 M	
3. SEX: FEMALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 06 08 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington Co. MD.
10. CITY OR TOWN OF DEATH: HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Co. HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Attendant	12b. KIND OF BUSINESS OR INDUSTRY: School
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: Washington	13c. CITY OR TOWN: Clear Spring	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: MAIN St. CLEAR SPRING, MD. 21722
14. FATHER'S NAME FIRST: ALLEN MIDDLE LAST: TOSTEN		15. MOTHER'S MAIDEN NAME FIRST: CARRIE MIDDLE LAST: ROCK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): NO	16b. SOCIAL SECURITY NO.: 215-36-7220	17. INFORMANT: Esther Brennan	ADDRESS: PO BOX 23 CLEAR SPRING MD 21722

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cerebral Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes Mellitus, Atherosclerotic Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute Myocardial Infarct.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from Dec 19 86 to 2/6 19 89, that (I) (~~not~~) last saw the deceased alive on 2/6 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~not~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Mary E. Money M.D. — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 2/6/89.
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Mary E. Money	22e. ADDRESS: 1708 Oak Hill Ave, Hagerstown, Md 21740	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2-9-89	23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cemetary	23d. LOCATION CITY OR TOWN: Clear Spring COUNTY: Washington STATE: MD
24. FUNERAL DIRECTOR NAME: THOMPSON FUNERAL HOME INC. ADDRESS: CLEAR SPRING MD.	25a. DATE REC'D. BY REGISTRAR: FEB 8 '89	25b. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall	

025179 MAR 4 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06178
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return all papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: E VELYN	LAST: Weaver	2a. DATE OF DEATH MONTH: January	DAY: 28	YEAR: 1989
2b. HOUR: 445 PM					
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH: JULY DAY: 20 YEAR: 1926	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.		
10. CITY OR TOWN OF DEATH: HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): WASHINGTON COUNTY HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DOMESTIC	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: FREDERICK	13c. CITY OR TOWN: FREDERICK	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 126 ICE STREET 21701	
14. FATHER'S NAME FIRST: GEORGE	MIDDLE: WASHINGTON	LAST: CARROLL	15. MOTHER'S MAIDEN NAME FIRST: MAGGIE	MIDDLE: CORNELIA	LAST: PROCTER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 219-20-3483	17. INFORMANT: WILLIAM CARROLL	ADDRESS: 17 Orndorff Dr., Brunswick, MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Renal failure
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-17 19 89, to 1-28 19 89, that (I) (we) last saw the deceased alive on 1-28 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Osk Pur	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/28/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ABDUL WAHEED MD	22e. ADDRESS: 1610- Oak Hill Ave. Hagerstown, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/1/89	23c. NAME OF CEMETERY OR CREMATORY: HOPELAND CEMETERY	23d. LOCATION CITY OR TOWN: FREDERICK	COUNTY: FREDERICK STATE: MD
24. FUNERAL DIRECTOR NAME: G. DOUGLAS STAUFFER ADDRESS: 1621 Opossumtown Pike, Frederick, MD 21701		25a. DATE REC'D. BY REGISTRAR: JAN 31 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

023779 FEB 21 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 06179 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM M 1. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP 2

DHMH - 17 (VR A15 ME (5))

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH	DAY	YEAR	2b. HOUR
MYRTLE	VERA	WILES	Feb	17	1989	1.23 A
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	White	June 5, 1897	91 YRS.			February 17 89	1:23
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A		Washington MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown	Avalon Manor Nursing Home	Housewife	Home				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Wash.	Hagerstown	YES [ ] NO [X]	Stonecroft Court	21740

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Harvey	M.	Davis	Etta	L.	Pryor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		220-16-1914 A.	Boyd Wiles Jr. Williamsport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

888

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) congestive heart failure 428 — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3-5 days

DUE TO, OR AS A CONSEQUENCE OF

(b) and arteriosclerotic cardiovascular dis. 429 — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

fracture left humerus N812

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [X] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	Jan 24 89	fall at home

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	at home	102 Stonecroft coutt / Washington, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Edward W. Dittoll III TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED Feb 17 1989

EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dittoll III M.D. ADDRESS 217 W. Washington St. Hagerstown, M

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Feb. 17 1989	Smithsburg Crematory	Smithsburg, Wash, Md.

24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Davis Funeral Home	Smithsburg, Md.	FEB 21 89	Julia Davidson-Randall

64-46

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 06180

1. DECEASED NAME (TYPE OR PRINT): First Mary; Middle Lavene; Last Yantz
2a. DATE OF DEATH: Month February; Day 6; Year 1989
2b. HOUR: 1120A M
3. SEX: female
4. RACE: white
5. DATE OF BIRTH: Month February; Day 16; Year 1907
6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD.
10. CITY OR TOWN OF DEATH: Hagerstown
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Washington
13c. CITY OR TOWN: Hagerstown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 1004 Brinker Dr. 21740

14. FATHER'S NAME: First Jacob; Middle; Last Moses
15. MOTHER'S MAIDEN NAME: First Annie; Middle; Last Johnson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.:
17. INFORMANT: Shirley Logue, Hagerstown, Md. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Respiratory failure, pleural effusion
DUE TO, OR AS A CONSEQUENCE OF (c): Lymphatic Esophagitis severe
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
massive GI bleeding GI tract failure

19a. DATE OF OPERATION: 1/18/89
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Rectal cancer resection
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2):
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 19 88 to [illegible] 19 89, that (I) (we) last saw the deceased alive on [illegible] 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE:
DEGREE: MD
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/7/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): [illegible] MD
22e. ADDRESS: 370 Mill St. Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial
23b. DATE: Feb. 9, 1989
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Gardens
23d. LOCATION: CITY OR TOWN; COUNTY; STATE: Cumberland, Alleg., Maryland

24. FUNERAL DIRECTOR NAME AND ADDRESS: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740
25a. DATE REC'D. BY REGISTRAR: FEB 8 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible] the event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

023621 FEB 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 89 06181

1. DECEASED NAME (TYPE OR PRINT): FIRST Joann MIDDLE Elizabeth LAST YOUNG

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH Feb DAY 6 YEAR 1989 — 2b. HOUR p M

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH MONTH April DAY 21 YEAR 1942 — 6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH Feb DAY 6 YEAR 1989 — 2d. HOUR 650 p M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY? U.S.A — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Washington MD

10. CITY OR TOWN OF DEATH: Hagerstown — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 33 W. Antietam St. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer — 12b. KIND OF BUSINESS OR INDUSTRY: News Distributor

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Wash. — 13c. CITY OR TOWN: Hagerstown — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 33 W. Antietam St. 21740

14. FATHER'S NAME: FIRST Harry MIDDLE L. LAST Rudy

15. MOTHER'S MAIDEN NAME: FIRST Mary MIDDLE L. LAST Huntsberry

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-36-4068

17. INFORMANT: Kevin L. Moats — ADDRESS: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic obst. lung disease, nicotine abuse

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: H. Weeks — M.D. — TITLE (SPECIFY): D-p MEDICAL EXAMINER — DATE SIGNED: Feb 7, 89

EXAMINER'S NAME (TYPE OR PRINT): H. N. Weeks — ADDRESS: 680 Northern Av Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: Feb. 10, 1989 — 23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery — 23d. LOCATION CITY OR TOWN Smithsburg COUNTY Wash STATE Md.

24. FUNERAL DIRECTOR NAME: Davis Funeral Home — ADDRESS: Smithsburg, Md. — Dennis L. Davis

25a. DATE REC'D. BY REGISTRAR: FEB 9 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 6

DHMH - 17 (VR A15 ME (5))

025173 MAR 14

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06182 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Tempie	Easterday	Zimmerman	1	23	89 / 7:25p M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
female	white	7	26	1892	96 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Washington County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Boonsboro, MD	Reeders Memorial Home	candy dipper	candy store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Frederick	Frederick	YES ☐ NO ☒	5531 Jefferson Pike 21701

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Elisha	Howard	Easterday	Mary	Virginia	King

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		217-18-8718 A	Catherine Burdette, 5531 Jefferson Pike,	Frederick, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) CHF, pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) diabetes mellitus - NIDDM, CAD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

diabetes mellitus, NIDDM, CAD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
CREMATION	1/28/89	SMITHSBURG CREMATORY	SMITHSBURG	WASHINGTON	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
G. DOUGLAS STAUFFER	1621 Opossumtown Pike, Frederick, MD 21701	JAN 27 1989	Julia Davidson-Randall

FEB 2 1989

024893 MAR -8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 6 1 8 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE - WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Leslie	MIDDLE: Juliet	LAST: Alley	2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] MONTH DAY YEAR: 2-15-89		2b. HOUR: M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Sept. 18, 53	6. AGE (IN YEARS LAST BIRTHDAY): 35 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 2-15- 1989	2d. HOUR: 7:35P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.			
10. CITY OR TOWN OF DEATH: Fruitland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): N.E. corner S. Division & Slab Bridge Rd.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dresser	12b. KIND OF BUSINESS OR INDUSTRY: Wayne				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: Rt. #1, Box 712	21801		
14. FATHER'S NAME: FIRST EMMET MIDDLE THOMAS LAST MELAND			15. MOTHER'S MAIDEN NAME: FIRST ADA MIDDLE POWELL LAST MELAND				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-60-8851	17. INFORMANT: HARRY ALLEY	ADDRESS: Rt. #1, Box 712 Salisbury, MD 21801				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cranio-cerebral injuries and total body thermal burn

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) XXXXXXXXXXXXXXXXXXXX injuries

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [XX] NO [ ]
21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR: 7:10PM 2-15-89	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/fixed object collision
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road	21f. LOCATION STREET OR R.F.D. CITY OR TOWN STATE: N.E. corner S. Division & Slab Bridge Rd. Fruitland, Wicomico County, Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy [XX] Inspection [ ] Inquiry [ ], death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] TITLE (SPECIFY) M.D.: Assistant MEDICAL EXAMINER DATE SIGNED: 2-16-89

VC EXAMINER'S NAME (TYPE OR PRINT): James Kaplan, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 02-17-89	23c. NAME OF CEMETERY OR CREMATORY: Salisbury Crematory	23d. LOCATION CITY OR TOWN: Salisbury	COUNTY: WI	STATE: MD
24. FUNERAL DIRECTOR NAME: Holloway Funeral Home	ADDRESS: 501 Snow Hill Rd. Salisbury, MD	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pendelle		

07/84 25M BP 10

DHMH - 17 (VR A15 ME (5))

023320 FEB 21 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

39 06184
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Minnie	MIDDLE: Hartsoe	LAST: Ashley	2a. DATE OF DEATH MONTH: January DAY: 28 YEAR: 1989	2b. HOUR: 1020 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 18, 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.	
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Princess Anne	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt. 3 Box 16 K 21853
14. FATHER'S NAME FIRST: Emory	MIDDLE	LAST: Hartsoe	15. MOTHER'S MAIDEN NAME FIRST: Candis	MIDDLE	LAST: Hartsoe
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-20-4834	17. INFORMANT: Mrs. Emily Abbott	ADDRESS: Rt.3 Box 16K Princess Anne, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Failure, Dm, Chronic Anemia, Old CVA,

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ~~I~~ (this hospital) attended the deceased from 1-24- 19 89 to 1-28- 19 89, that (I) (~~we~~) last saw the deceased alive on 1-26- 19 89, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~have~~) (did not) view the body after death.

22b. SIGNATURE: Dagger — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1-31-89

22d. PHYSICIAN'S NAME (TYPED OR PRINTED): D. SAGGAR

22e. ADDRESS: PENINSULA GENERAL HOSPITAL MED. CENTER SALISBURY, MD. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/31/1989	23c. NAME OF CEMETERY OR CREMATORY: Beechwood	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Princess Anne; Somerset, Md	
24. FUNERAL DIRECTOR NAME: James L. Kinnamon ADDRESS: Princess Anne	25a. DATE REC'D. BY REGISTRAR: FEB 1 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

124759 MAR-7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 061855

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: IRENE	MIDDLE: GLADYS	LAST: BARNETTE	2a. DATE OF DEATH MONTH DAY YEAR: FEB. 07 1989	2b. HOUR: M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 15, 1922	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SALISBURY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 201 E. Lincoln Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Shirt Factory	12b. KIND OF BUSINESS OR INDUSTRY: Cutter	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 201 E. Lincoln Ave., 21801	
14. FATHER'S NAME FIRST: William	MIDDLE: Thomas	LAST: McDaniel	15. MOTHER'S MAIDEN NAME FIRST: Emma	MIDDLE: ---	LAST: Revel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219-14-4782	17. INFORMANT: Paul Barnette	ADDRESS: 201 E. Lincoln Ave. Salisbury, MD 21801	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer Lung with Brain Metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cancer Metastasis.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Risk of Cancer Breast, Diabetes, Chronic Pulmonary

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/7, 19 83, to 2/7, 19 89, that (I) (we) last saw the deceased alive on 2/7, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature], MD — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): — 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 02-10-89	23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery	23d. LOCATION CITY OR TOWN: Salisbury	COUNTY: WI STATE: MD
24. FUNERAL DIRECTOR NAME: Holloway Funeral Home	ADDRESS: 501 Snow Hill Rd Salisbury, MD	25a. DATE REC'D BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Russell		

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

024754 M.R. — 1 – STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06186 — REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in obtaining the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Elizabeth; MIDDLE: Leona; LAST: Bishop			2a. DATE OF DEATH — MONTH DAY YEAR: 2 4 89	2b. HOUR: 2:45 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH — MONTH DAY YEAR: May 7, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ohio	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.	
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Delaware	Sussex	Seaford	YES [ ] NO [X]	19973 Delaware 1806 Poncord Rd. Seaford

14. FATHER'S NAME — FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST
Herbert / Amos / Gibson	Elizabeth / / Knicely

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT — ADDRESS
No	None	296-12-9399	Paul L. Bishop 1806 Poncord Rd. Seaford, Del. 19973

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b): CA of the lungs

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M./P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that ~~I~~ (this hospital) attended the deceased from 1/25, 19 89, to 2/4, 19 89, that (I) (we) last saw the deceased alive on 2/4, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Constante J Tan	M.D.	[ ] / [ ] / [X]	2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CONSTANTE J TAN	547-D Riverside Dr Salsbug, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	2-7-89	Hillcrest Cemetery	Federalsburg Car. Md.

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Williamson Funeral Home / 21632 Federalsburg, MD.	FEB 03 89	

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

024822 MAR -7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06187
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and transmitted by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: WANDA; MIDDLE: L; LAST: BIVENS				2a. DATE OF DEATH — MONTH: Feb.; DAY: 12; YEAR: 1989	2b. HOUR: 0915 M
3. SEX: F	4. RACE: Blk	5. DATE OF BIRTH — MONTH: 10; DAY: 23; YEAR: 39		6. AGE (IN YEARS LAST BIRTHDAY): 49 YRS.	IF UNDER 1 YEAR: MONTHS; DAYS — IF UNDER 24 HRS: HOURS; MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Salisbury	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Nurses Asst.	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Wico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 701 Mohawk Ave. Salisbury, Md.	
14. FATHER'S NAME — FIRST: Elwood; MIDDLE: Jones; LAST:				15. MOTHER'S MAIDEN NAME — FIRST: Virginia; MIDDLE: Dennis; LAST: Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-34-5328		17. INFORMANT — ADDRESS: Roland Bivens 701 Mohawk Ave. Salisbury, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Breast Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2/12 19 89 to 2/17 19 89, that (I) (~~we~~) last saw the deceased alive on 2/12 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Joseph N. Grasso	DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/12/89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph N. GRASSO MD	22e. ADDRESS: 145 E. CARROLL ST. SALISBURY MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-17-89	23c. NAME OF CEMETERY OR CREMATORY: Green Acres Cemt.	23d. LOCATION — CITY OR TOWN: Salisbury; COUNTY: Wico; STATE: Md.	
24. FUNERAL DIRECTOR — NAME: LEWIS N. WATSON F/H; ADDRESS: Nest Rd. Salisbury	25a. DATE REC'D. BY REGISTRAR: FEB 16 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randolph		

BP 10

DHMH - 1650M 1/81
(VRA 15, 4)

023095 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06188
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Mary — MIDDLE: — LAST: Bowen

2a. DATE OF DEATH — MONTH: January — DAY: 29 — YEAR: 1989

2b. HOUR: 0350 M

3. SEX: Female.

4. RACE: Black

5. DATE OF BIRTH — MONTH: 9 — DAY: 3 — YEAR: 1910

6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina

7b. CITIZEN OF WHAT COUNTRY?: U. S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.

10. CITY OR TOWN OF DEATH: SALISBURY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife.

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Wicomico — 13c. CITY OR TOWN: Salisbury — 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: Wicomico Nursing Home 2801

14. FATHER'S NAME — FIRST: John — MIDDLE: — LAST: Smith

15. MOTHER'S MAIDEN NAME — FIRST: unknown — MIDDLE: — LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Leroy King — ADDRESS: P.O. 231 Snow Hill, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): dementia

DUE TO, OR AS A CONSEQUENCE OF (c): Multiple cerebral infarcts

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/4 19 87 to 1/29 19 89 that (I) (we) last saw the deceased alive on 1/28 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William H. Cole — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑

22c. DATE SIGNED: 1/29/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT):

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-3-89

23c. NAME OF CEMETERY OR CREMATORY: Richardson

23d. LOCATION — CITY OR TOWN: Easton — COUNTY: Talbot — STATE: Md.

24. FUNERAL DIRECTOR — NAME: Bennie Smith — ADDRESS: P.O. Box 928 Hurlock, Md.

25a. DATE REC'D. BY REGISTRAR: FEB 02 '89

25b. REGISTRAR'S SIGNATURE: Julie Davidson-Rondeau

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6 1

DHMH - 16 50M 1/81 (VRA 15, 4)

0 2 3 4 6 1 FEB 22 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06189

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MILTON — MIDDLE: Clayton — LAST: Bozman SR.

2a. DATE OF DEATH — MONTH: February — DAY: 5 — YEAR: 1989

2b. HOUR: 0908 A M

3. SEX: MALE

4. RACE: White

5. DATE OF BIRTH — MONTH: May — DAY: 29 — YEAR: 1914

6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DELAWARE

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.

10. CITY OR TOWN OF DEATH: SALISBURY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): PAINTER

12b. KIND OF BUSINESS OR INDUSTRY: HOUSE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: WICOMICO — 13c. CITY OR TOWN: PARSONSBURG — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: RT #2 BOX 86 — 21849

14. FATHER'S NAME — FIRST: John — MIDDLE: Clayton — LAST: Bozman

15. MOTHER'S MAIDEN NAME — FIRST: MARY — MIDDLE: ELIZABETH — LAST: BAKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217-09-3765

17. INFORMANT: Coedellia L. Bozman — ADDRESS: SAME AS 13C

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Weeks
DUE TO, OR AS A CONSEQUENCE OF
(b): Chronic Obstructive Lung Disease — years
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Congestive Heart Failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from Jan 26, 19 89, to Feb 5, 19 89, that (I) (~~we~~) last saw the deceased alive on Feb 5 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Thomas C Hill Jr. — DEGREE: M.D. — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/5/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS C. HILL JR

22e. ADDRESS: Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/9/1989

23c. NAME OF CEMETERY OR CREMATORY: Jerusalem Com.

23d. LOCATION — CITY OR TOWN: Parsonsburg — COUNTY: Md. — STATE

24. FUNERAL DIRECTOR — NAME AND ADDRESS: Bounds Funeral Home, Salisbury Md

25a. DATE REC'D. BY REGISTRAR: FEB 06 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rinaldi

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

023172 FEB 17 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06190 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Esther	MIDDLE: M	LAST: Bradford	2a. DATE OF DEATH MONTH DAY YEAR: 01 31 89	2b. HOUR: 4:50 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 07 05 18	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.	
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Eden	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: RT #1 Box 69 Meadow Bridge Rd. 21822
14. FATHER'S NAME FIRST: Rolla	MIDDLE: M.	LAST: Beatty	15. MOTHER'S MAIDEN NAME FIRST: Elsie	MIDDLE / LAST: Eckhardt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 171-14-8625	17. INFORMANT: Edward Bedford	ADDRESS: Same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Glioblastoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Summer 1988
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-2 19 89 to 1-31 19 89 that (I) (we) last saw the deceased alive on 1-31 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Inja J. Hwang — DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Inja J. Hwang — 22e. ADDRESS: Deer's Head Center Salisbury Md 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/2/1989	23c. NAME OF CEMETERY OR CREMATORY: Bethel Memorial Gdn	23d. LOCATION CITY OR TOWN: Acworth	COUNTY	STATE: Md.
24. FUNERAL DIRECTOR NAME: Bounds Funeral Home	ADDRESS: Salisbury Md	25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

24579 MAR -3 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 06191

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): FIRST WILLIAM MIDDLE A. LAST Calvey
2a. DATE OF DEATH: MONTH February DAY 19 YEAR 1989
2b. HOUR: 0520 M
3. SEX: Male
4. RACE: WHITE
5. DATE OF BIRTH: MONTH DAY YEAR 10-15-02
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): N.J.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): STEELWORKER
12b. KIND OF BUSINESS OR INDUSTRY: STEEL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: WOR
13c. CITY OR TOWN: O. CITY
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: EXETER Rd 21842

14. FATHER'S NAME: FIRST WILLIAM MIDDLE LAST CALVEY
15. MOTHER'S MAIDEN NAME: FIRST ANNA MIDDLE HEARNE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 193-05-4358
17. INFORMANT: F.E. CALVEY ADDRESS: Ocean City MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b): respiratory arrest — 7 days
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): subdural hematoma

19a. DATE OF OPERATION: 2/6/89
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: subdural hematoma
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/18 19 89 to 2/19 19 89, that (I) (we) last saw the deceased alive on 2/18 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Peter Sebastian DEGREE: DO ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 2/19/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): PETER SEBASTIAN D.O
22e. ADDRESS: 510 Riverside Dr. Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 2-21-89
23c. NAME OF CEMETERY OR CREMATORY: SUNSET M.P.
23d. LOCATION: CITY OR TOWN Berlin COUNTY Wor STATE MD

24. FUNERAL DIRECTOR: NAME ULRICH F.H. ADDRESS Berlin, Md.
25a. DATE REC'D. BY REGISTRAR: FEB 21 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

023963 FEB 28 19 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06192

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	Arnettia M. Camper
2a. DATE OF DEATH MONTH DAY YEAR	February 11, 1989
2b. HOUR	245 A M
3. SEX	Female
4. RACE	BLK
5. DATE OF BIRTH MONTH DAY YEAR	May 29 38
6. AGE (IN YEARS LAST BIRTHDAY)	50 YRS.
IF UNDER 1 YEAR MONTHS DAYS	
IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Wicomico County MD.
10. CITY OR TOWN OF DEATH	Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Deer's Head Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	FOOD SERVICE
12b. KIND OF BUSINESS OR INDUSTRY	Campbell Soup
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.
13b. COUNTY	Wico
13c. CITY OR TOWN	Wetipquin
13d. INSIDE CITY LIMITS? YES ☐ NO ☑	
13e. STREET ADDRESS	B/92 Quantico Md. 21856
14. FATHER'S NAME FIRST MIDDLE LAST	Marcellas Camper
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Ella Mae
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	218-34-8085
17. INFORMANT ADDRESS	Gregory Camper Quantico md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Neurosarcoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Congenital Neurofibromatosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-05 19 89 to 2-11 19 89 that (I) (we) last saw the deceased alive on 2-11 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	Elsa M. Goris M.D	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	ELSA M. GORIS	22e. ADDRESS Deer's Head Center, Salisbury, Md 21801
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE Feb 11, 1989
23c. NAME OF CEMETERY OR CREMATORY	Friendship CH Cem	23d. LOCATION CITY OR TOWN Wetipquin COUNTY Wico STATE Md.
24. FUNERAL DIRECTOR NAME Fooks F/H	ADDRESS P.O.B 1574 Salisbury md	25a. DATE REC'D. BY REGISTRAR FEB 13 '89
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

023319 FEB 21 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 061933 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: Thomas	LAST: CLEVENGER Jr	2a. DATE OF DEATH MONTH DAY YEAR: January 27, 1989	2b. HOUR: 2335 M	
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan 9, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Missouri	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Princess Anne	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt 2	2853
14. FATHER'S NAME FIRST: James	MIDDLE: Thomas	LAST: Clevenger	15. MOTHER'S MAIDEN NAME FIRST: Margaret	MIDDLE	LAST: Clevenger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 096-07-4302	17. INFORMANT: Mary Ward Clevenger	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): chronic obstructive lung disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12-26-87, 19____, to 1-27-87, 19 87, that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1-27-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 1/31/89	23c. NAME OF CEMETERY OR CREMATORY: Beechwood	23d. LOCATION CITY OR TOWN: Princess Anne / COUNTY: Somerset / STATE: Md	
24. FUNERAL DIRECTOR NAME: Homer L. Wenner	ADDRESS: Princess Anne Md	25a. DATE REC'D. BY REGISTRAR: FEB 1 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024842 MAR -7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06194
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Hattie	Middle: E	Last: Coleman	2a. DATE OF DEATH Month Day Year: February 20, 1989	2b. HOUR: 2:50 P M	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH Month Day Year: 8 6 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Dor.	13c. CITY OR TOWN: Hurlock	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: P.O. Box 355 - 21643	
14. FATHER'S NAME First: Robert	Middle:	Last: Conaway	15. MOTHER'S MAIDEN NAME First: Lettie	Middle:	Last: Jones
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 200-09-6664	17. INFORMANT: Terry Simms	ADDRESS: P.O. Box 355 Hurlock, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Failure	48 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Aspiration Pneumonia	48 hours
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Metastatic Breast Cancer - COPD - MI.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-14, 1989, to 2-20, 1989, that (I) (we) last saw the deceased alive on 2-20 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-20-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): EVANGELOS LIGNOS M.D.	22e. ADDRESS: MEDICAL CENTER N #6 SALISBURY	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-24-89	23c. NAME OF CEMETERY OR CREMATORY: Md. Veterans	23d. LOCATION CITY OR TOWN: Beulah	COUNTY: Dor. STATE: Md.
24. FUNERAL DIRECTOR NAME: Bennie Smith	ADDRESS: P.O. 928 Hurlock, Md.	25a. DATE REC'D. BY REGISTRAR: MAR 3 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024758 MAR -7 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06195

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: When the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for the issuance of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
KENTWORTH	C.	Cooksey

2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
February	7	1989	2214 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	Apr. 25, 1907	81 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
VIRGINIA	USA		WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	PENINSULA GENERAL HOSPITAL	Retired Poultry	Grower

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES ☐ NO ☐	905 S. Division St., 21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ROSS	--	COOKSEY	MAUDE	--	SIMPSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		215-20-4794	Vernon L. Taylor	115 McKinley Drive Salisbury, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARREST.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	EMPHYSEMA.	
DUE TO, OR AS A CONSEQUENCE OF (c)	CORONARY ARTERY DISEASE	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/2, 19 87, to 2/7, 19 89, that (I) (we) last saw the deceased alive on 2/8, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William H. Robbins	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
William Robbins	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	02-10-89	Springhill Memory	Salisbury	WI	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home	501 Snow Hill Road Salisbury, MD	FEB 9 '89	Julia Davidson Register

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

23457 FEB 22 89 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06196 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Miya (Baby) Middle:	Last: CORBIN	2a. DATE OF DEATH Month: FEB Day: 6 Year: 89	2b. HOUR 2:52PM		
3. SEX: FEMALE	4. RACE: BLACK	5. DATE OF BIRTH Month: FEB Day: 6 Year: 89	6. AGE (IN YEARS LAST BIRTHDAY): 0 YRS.	IF UNDER 1 YEAR Months: 0 Days: 0	IF UNDER 24 HRS. Hours: 0 Min.: 14
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): —	12b. KIND OF BUSINESS OR INDUSTRY: —		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Som.	13c. CITY OR TOWN: Manokin	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: P.O. Box 52	21836
14. FATHER'S NAME First: Russell Middle: Last: Corbin		15. MOTHER'S MAIDEN NAME First: Joanne Middle: Last: Corbin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: Joanne Corbin	ADDRESS: Manokin Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): SEVERE PREMATURITY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 mins

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 6 19 89 to FEBRUARY 6 19 89, that (I) (we) last saw the deceased alive on FEBRUARY 6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.

22b. SIGNATURE: Francis J. Montone	DEGREE: D.O. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: FEB 6, 1989	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): FRANCIS J. MONTONE DO	22e. ADDRESS: ROUTE 8 BOX 266 PHILLIP MORRIS DRIVE SALISBURY		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/7/89	23c. NAME OF CEMETERY OR CREMATORY: Samuel Wesley	23d. LOCATION CITY OR TOWN: Manokin COUNTY: Som. STATE: Md.
24. FUNERAL DIRECTOR NAME: Anthony Edward Crisfield ADDRESS: MD.	25a. DATE RECD. BY REGISTRAR: FEB 8 89	25b. REGISTRAR'S SIGNATURE:	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

023440 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 06197

1. DECEASED NAME (TYPE OR PRINT): FIRST RALPH — MIDDLE — LAST COTTMAN

2a. DATE OF DEATH: MONTH 2 DAY 1 YEAR 89

2b. HOUR 4A M

3. SEX: MALE

4. RACE: Negro

5. DATE OF BIRTH: MONTH 8 DAY 11 YEAR 35

6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer Head Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. 13b. COUNTY: Somerset 13c. CITY OR TOWN: Pocomoke 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS: Rt. 1 Box 243 21851

14. FATHER'S NAME: FIRST Willie MIDDLE LAST Cottman

15. MOTHER'S MAIDEN NAME: FIRST Ruth MIDDLE LAST Miles

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 214-34-5988

17. INFORMANT: Betty Ann Taylor ADDRESS: P.O. Box 1112 Gridetree, Md. 21829

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lung Cancer c brain metastasis
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1987

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-14 19 89 to 2-1 19 89, that (I) (we) last saw the deceased alive on 2-1 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Inja J. Hwang DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/11/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): INJA JOE HWANG

22e. ADDRESS: DEERS HEAD CENTER - EMERSON ST. SALISBURY

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-4-89

23c. NAME OF CEMETERY OR CREMATORY: Tindley Mem. Gem.

23d. LOCATION CITY OR TOWN: Pocomoke COUNTY: Somerset STATE: Md.

24. FUNERAL DIRECTOR NAME: Samuel H. Savage ADDRESS: New Church, Va.

25a. DATE REC'D. BY REGISTRAR: FEB 02 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson Register

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

P

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

024867 MAR -8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06198

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Albert Cottman - Sr.		2a. DATE OF DEATH MONTH DAY YEAR: 2/19/89	2b. HOUR: 1:15 M
3. SEX: M	4. RACE: B	5. DATE OF BIRTH MONTH DAY YEAR: 1 1 1921	6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.
2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): River Walk Manor	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Farmer

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Som	Princess Anne	YES ☐ NO ☒	RT-3 Box 523 21853

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Gilbert Cottman	Molly Cottman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		217-16-9178	Josephine Smith - Princess Anne Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Esophagus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr. (?)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that ~~(if~~ (this hospital) attended the deceased from Feb 10, 19 89, to Feb 19, 19 89, that ~~(if~~ (we) last saw the deceased alive on Feb 19 19 89, and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~(if)~~ (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Thomas C Hill Jr M.D	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	2/19/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
THOMAS C. Hill JR M.D	Pine Bluff Road, Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/25/89	Christ ME.	Rehoboth Som Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hutton E. Ward Crisfield Md.	FEB 22 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 1

DHMH - 16 50M 1/81 (VRA 15, 4)

023657 FEB 23 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 06199

1. DECEASED NAME (TYPE OR PRINT): Laura S. Cranfield
2a. DATE OF DEATH: 02 14 89
2b. HOUR: 2:20 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: December 11 1903
6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wicomico NH
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Willards
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Bethel Road 21874

14. FATHER'S NAME: Harry Smith
15. MOTHER'S MAIDEN NAME: Bell Hudson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 219-60-1660
17. INFORMANT ADDRESS: Dorothy Twilley, Willards, Maryland 21874

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia's
DUE TO, OR AS A CONSEQUENCE OF (b): influenza
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1 6 79, 19__ to Feb 14, 19 89, that (I) (we) last saw the deceased alive on Feb 14 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2-14-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): F.C. Arthes MD
22e. ADDRESS: 3 Bay St Berlin, Md 21811

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2-18-89
23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
23d. LOCATION CITY OR TOWN: Willards COUNTY: Wicomico STATE: MD

24. FUNERAL DIRECTOR NAME / ADDRESS: Charles W Hastings Jr Selbyville Delaware
25a. DATE REC'D. BY REGISTRAR: FEB 17 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows a body injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

023795 FEB 2 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 24 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06200
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MILDRED	MIDDLE: GOLDIE	LAST: Disharoon	2a. DATE OF DEATH MONTH DAY YEAR: February 2 1989	2b. HOUR: 1130 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: MAY 04, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: SALES

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WICOMICO	SALISBURY	YES ☐ NO ☐	ALABAMA AVENUE, 21801

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
IRA / -- / McALLISTER	ELLA / -- / WEBSTER	NO	217-10-2343	Wayne Taylor 604 Ridge Road Salisbury, MD 21801

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO Arrest for Collapse.
DUE TO, OR AS A CONSEQUENCE OF (b): Atrial Fibrillation
DUE TO, OR AS A CONSEQUENCE OF (c): Hip Fracture
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): atrial fibrillation · dementia · fracture right hip

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (~~this hospital~~) attended the deceased from 1/20, 19 89, to 2/2, 19 89, that (I) (~~saw~~) last saw the deceased alive on 2/1, 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~saw~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE / DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Rodney A Wenrich, MD	☐ ☒ ☐	2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RODNEY A. WENRICH	100 POWER ST. SALISBURY Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	02-04-89	wicomico memorial	Salisbury WI MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home, P.A. Salis., MD 501 Snow Hill Rd.	FEB 07 '89	Julia Davidson-Randall

0-237902 FEB 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06201

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: DANIEL	MIDDLE: J.	LAST: ~~DiTonno~~ DiTonno	2a. DATE OF DEATH MONTH: 2	DAY: 7	YEAR: 89	2b. HOUR: 9:14 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 6 DAY: 5 YEAR: 17	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.				
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): REPAIR	12b. KIND OF BUSINESS OR INDUSTRY: SHOE				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	WOR	OCEAN CITY	YES ☒ NO ☐	308 26TH ST 21842

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
DOMINIC	DITONNO		JENNIE	M.	DITONNO

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WWII	212-12-0486	F.F. DITONNO	OCEAN CITY

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 2/3 19 89 to 2/7 19 89, that (I) ~~(no)~~ last saw the deceased alive on 2/7 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(no)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Wm B Horner MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Wm. Benjamin Horner MD.	

23a. BURIAL, CREMATION, REMOVAL (CIRCLE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-10-89	HOLY REDEEMER	BALTIMORE, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ULRICH F.H. BERLIN, MD.	FEB 09 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail or deliver pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 8

DHMH - 1650M 1/81 (VRA 15, 4)

024755 MAR 7 '89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 9 0 6 2 0 2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P/M 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Gene	MIDDLE T	LAST Dukes	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH 2/5 DAY YEAR 19 89		2b. HOUR 1405 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 07 DAY 24 YEAR 1926	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH Feb. DAY 5 YEAR 19 89	2d. HOUR 1405 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant	12b. KIND OF BUSINESS OR INDUSTRY Jeweler				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware	13b. COUNTY Sussex	13c. CITY OR TOWN Delmar	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS Rt. 2, P.O.Box 83			
14. FATHER'S NAME FIRST B. Frank MIDDLE Dukes LAST		15. MOTHER'S MAIDEN NAME FIRST Blanch MIDDLE Treehearn LAST [illegible]					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes	(IF YES, GIVE WAR OR DATES) Korea	16b. SOCIAL SECURITY NO. 220-24-5024	17. INFORMANT Katherine Dukes	ADDRESS same			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE Thomas C Hill Jr. M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2/5/89

EXAMINER'S NAME (TYPE OR PRINT) Thomas C. Hill Jr. M.D. ADDRESS Pine Bluff Rd., Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-8-1989	23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem.	23d. LOCATION CITY OR TOWN Delmar	COUNTY Sussex STATE Delaware
24. FUNERAL DIRECTOR NAME Short Funeral Home ADDRESS Delmar, DE 19940		25a. DATE REC'D. BY REGISTRAR FEB 9 '89	25b. REGISTRAR'S SIGNATURE [signature]	

07/84 25M BP 7 DHMH 10 (VR A10 M6 (5))

023462 FEB 2 1989 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06203 REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Marie - Louise Lucie R. Durand	2a. DATE OF DEATH MONTH DAY YEAR	2-3-89	2b. HOUR	1:30A M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	12 12 1913
6. AGE (IN YEARS LAST BIRTHDAY)	75 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Massachusetts	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	WICOMICO COUNTY MD.				
10. CITY OR TOWN OF DEATH	SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SALISBURY NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Machine Operator
12b. KIND OF BUSINESS OR INDUSTRY	Garment Ind.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES ☐ NO ☒	795 Coulbourne Mill Rd. 21801

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Francois X. Durand	Euphemie Bertrand

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		014-09-0808	Mrs. John Pieroni	Same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bacterial Sepsis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): S/P Massive Cerebral Hemorrhage

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
☐	19	

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 1-19-87 to 2-3-89, that (I) (we) last saw the deceased alive on 2-3-89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Mark Speake M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARK SPEAKE, M.D.	106 Mt. Vernon Rd., Princess Anne, Md. 21853

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-7-1989	Notre Dame Cemetery	Fall River Bristol Mass.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
BOUNDS FUNERAL HOME	SALISBURY, MARYLAND	FEB 06 '89	Julia Davidson-Registrar

BP 11

DHMH - 16 50M 1/81 (VRA 15, 4)

022094 FEB -9 89 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06204 — REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: MARGARET	MIDDLE: V.	LAST: ELLIOTT	2a. DATE OF DEATH: MONTH FEBRUARY, DAY 1, YEAR 1989		2b. HOUR: 1439 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: MONTH Feb. DAY 27, YEAR 1926	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.			
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner	12b. KIND OF BUSINESS OR INDUSTRY: Care Home			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Somerset	Crisfield	YES [ ] NO [X]	Chesapeake Ave., Ext. Box 190 - Crisfield, MD 21817

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Ernest	C.	Walker	Marie		Hye

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	- - -	220-16-9945	Charles L. Elliott	same as 13 abcde

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ADENO CARCINOMA of LUNG WITH METASTASIS TO BONE
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CHF, RENAL TUMOR, DM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/30 19 88, to 2/1 19 89, that (I) (we) saw the deceased alive on 2/1 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Ronald P. Travitz MD	MD	ATTENDING PHYSICIAN [X]	MEDICAL DIRECTOR [ ]	STAFF PHYSICIAN [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RONALD P. TRAVITZ	560 RIVERSIDE DRIVE SALISBURY MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
Burial	02-04-89	Sunnyridge Cemetery	Crisfield - Somerset - MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradshaw & Sons	Crisfield MD 21817	FEB 7 1989	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

023709 FEB 17 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - STATE REGISTRAR

REG. NO. 89 06205

1. DECEASED NAME (TYPE OR PRINT): Edward (FIRST) Dawson (MIDDLE) Everett (LAST) Sr.

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ]: MONTH 2/2 DAY YEAR 1989 — 2b. HOUR 0005 M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 03 DAY 03 YEAR '18 — 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 2 YEAR 1989 — 2d. HOUR 0005 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b. CITIZEN OF WHAT COUNTRY?: U.S. — 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.

10. CITY OR TOWN OF DEATH: Salisbury — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Manager — 12b. KIND OF BUSINESS OR INDUSTRY: Chemical

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Worcester — 13c. CITY OR TOWN: Berlin — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: Rt. 2, Box 132 21811

14. FATHER'S NAME: Walter (FIRST) (MIDDLE) Everett (LAST)

15. MOTHER'S MAIDEN NAME: Mandy (FIRST) (MIDDLE) Blackston (LAST)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes — (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 218-03-3418

17. INFORMANT: Ara J. Everett, — ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 2/2/1989

EXAMINER'S NAME (TYPE OR PRINT): Thomas C. Hill Jr., M.D. — ADDRESS: Pine Bluff Rd., Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — 23b. DATE: 2-5-89 — 23c. NAME OF CEMETERY OR CREMATORY: SUNSET M.P. — 23d. LOCATION CITY OR TOWN: BERLIN COUNTY: WOR STATE: MD.

24. FUNERAL DIRECTOR: ULRICH F.H. — ADDRESS: BERLIN, MD.

25a. DATE REC'D. BY REGISTRAR: FEB 06 '89 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M — BP 10 — DHMH - 17 (VR A15 ME (5))

023962 FEB 28 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006206
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (or use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): FIRST E. Paige MIDDLE LAST Ewell
2a. DATE OF DEATH: MONTH February DAY 9, YEAR 1989
2b. HOUR: 11:57 A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH 7 DAY 11 YEAR 16
6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Parksley, Va.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Automobile

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: 200 Holland Ave. 21801

14. FATHER'S NAME: FIRST Alfred MIDDLE Roland LAST Ewell
15. MOTHER'S MAIDEN NAME: FIRST Merrill MIDDLE LAST Justis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 214-10-7141
17. INFORMANT: Vera J. Ewell, 200 Holland Ave., Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1/2 Hour
DUE TO, OR AS A CONSEQUENCE OF (b): embolus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): (L) Deep Vein thrombosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1 36 24 19 89 to 2 9 19 89, that (I) (we) last saw the deceased alive on 2 9 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Virginia D. Hofreuter DEGREE: M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Virginia Hofreuter
22e. ADDRESS: Deer's Head Center P.O. Box 2018 Emerson Ave. Salis. Md. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 2-11-89
23c. NAME OF CEMETERY OR CREMATORY: WICOMICO MEMORIAL
23d. LOCATION: CITY OR TOWN SALISBURY COUNTY WI STATE MD

24. FUNERAL DIRECTOR: NAME HOLLOWAY FUNERAL HOME, ADDRESS 501 Snow Hill Rd. Salisbury, Md. 21801
25a. DATE REC'D. BY REGISTRAR: FEB 13 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

023044 FEB 17 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06207
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
LESTER	ELIHU	FOOKS	JAN. 24, 1989	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	MAR. 24 1909	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	WESTSIDE TRAILER PARK	RETIRED	CARPENTER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WICOMICO	SALISBURY	YES ☐ NO ☐	Box 15, Star Route, Rt 349

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ALBERT	WASHINGTON	FOOKS	ROSA	--	CALOWAY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES		214-16-4435	Joanne F. Hill	Star Rt., Box 15, Rt. 349, Salisbury, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LUNG CARCINOMA WITH METASTASIS TO BRAIN
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/6 19 88 to 1/24 19 89, that (I) (we) last saw the deceased alive on 12/7 19 88, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Ronald P. Trawitz	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RONALD P. TRAWITZ	560 RIVERSIDE DR SALISBURY MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	01-27-89	Fooks Family Cem.	Salisbury WI MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home	501 Snow Hill Rd Salisbury, MD	JAN 31 '89	Julia Davidson-Ponder

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 7

DHMH - 16 50M 1/81 (VRA 15, 4)

023307 FEB 21 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062083
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
MABEL	F.	GATES	2	11	89	2:30am

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	White	Jan. 20, 1908	81 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	SALISBURY NURSING HOME	Housewife	- - -

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Somerset	Bivalve	YES ☐ NO ☒	MD Route 349 Box 6 (21814)

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Alfred		Fisher	Sarah		TRUITT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	214-12-6274	Nathaniel M. Gates	Same as 13 a,b,c,d,e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac - respiratory arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Central infarct	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/3, 19 87, to 2/11, 19 87, that (I) (we) last saw the deceased alive on ____, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William H. Robins	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
WM. H. ROBINS, M.D.	CIVIC AVE. & RT. 50, SAL., MD. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/16/89	Sunnyridge Cemetery	Crisfield Somerset MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradshaw & Sons	Crisfield, MD 21817	FEB 16 1989	Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

024289 FEB 23

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062099
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Emil / W. / Gibbas	2a. DATE OF DEATH — MONTH DAY YEAR	February 10 1989
		2b. HOUR	1618 M
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH — MONTH DAY YEAR	May 14, 1917	6. AGE (IN YEARS LAST BIRTHDAY)	71 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS		IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Ohio	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH	WICOMICO MD.
10. CITY OR TOWN OF DEATH	SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PENINSULA GENERAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Floor Manager	12b. KIND OF BUSINESS OR INDUSTRY	Steel
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Worcester
13c. CITY OR TOWN	Snow Hill	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET ADDRESS	Rt. 3 - Box 61 / 21863		
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Charles / / Gibas	15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Mary / / Estra
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	-----
16b. SOCIAL SECURITY NO.	232 07 5567	17. INFORMANT — ADDRESS	Donna L. Gibbas, Atlanta, Georgia

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Staphylococcal Sepsis due to GI Bleeding

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/28/89 to 2/10/89, that (I) (we) last saw the deceased alive on 2/10/89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Helen Baldado — DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED 2-10-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen Baldado — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Entombment	23b. DATE	2/13/89
23c. NAME OF CEMETERY OR CREMATORY	Wicomico Memorial	23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Salisbury, Maryland
24. FUNERAL DIRECTOR — NAME / ADDRESS	Norman F. Dennis, Snow Hill, Maryland	25a. DATE REC'D. BY REGISTRAR	FEB 13 '89
25b. REGISTRAR'S SIGNATURE	Gina Barker		

BP 15

DHMH - 1650M 1/81 (VRA 15, 4)

023108 FEB 1 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 062 10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROSIE	MIDDLE: V.	LAST: GOLDSBOROUGH	2a. DATE OF DEATH MONTH DAY YEAR: 01- 27-1989	2b. HOUR: 7:25 PM
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH DAY YEAR: APRIL 5, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor	12b. KIND OF BUSINESS OR INDUSTRY: Factory
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Kent	13c. CITY OR TOWN: Chestertown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: CALVERT ST.
14. FATHER'S NAME FIRST: CHARLES	MIDDLE:	LAST: STEVENSON	15. MOTHER'S MAIDEN NAME FIRST: LILLIAN	MIDDLE: LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 212-16-7277	17. INFORMANT: MRS. GLORIA JOHNSON	ADDRESS: CANNON ST CHESTERTOWN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac respiratory arrest.
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic renal failure
DUE TO, OR AS A CONSEQUENCE OF (c): Congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/5, 19 89, to 1/27, 19 89, that (I (we) last saw the deceased alive on ____, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. H. Robins
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): William H. Robins, M.D.
22e. ADDRESS: US 50-Civic Ave., Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/4/1989	23c. NAME OF CEMETERY OR CREMATORY: Rich Neck Hall	23d. LOCATION (CITY OR TOWN / COUNTY / STATE): Chestertown Kent Md.	
24. FUNERAL DIRECTOR (NAME): Arnold Wolf	ADDRESS: Chestertown, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 3 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 3

DHMH - 16 50M 1/81 (VRA 15, 4)

124964 MAR -8 89 1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062 11
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: PAULINE MIDDLE: A. LAST: GORDY				2a. DATE OF DEATH MONTH: 2 DAY: 16 YEAR: 89	2b. HOUR: 4:30 PM
3. SEX: FEMALE	4. RACE: AFRO-AMER.	5. DATE OF BIRTH MONTH: JULY DAY: 2, YEAR: 1925		6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WATHA N.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1201 SHAWNEE AVE.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: CAMPBELL SOUP
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: WICOMICO	13c. CITY OR TOWN: SALISBURY	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 1201 SHAWNEE AVE. 21801	
14. FATHER'S NAME FIRST: ARLEY MIDDLE: LAST: MITCHELL				15. MOTHER'S MAIDEN NAME FIRST: MARGARET MIDDLE: LAST: COSTEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 218-16-7496		17. INFORMANT: LEO GORDY, SR. ADDRESS: ADD. SAME AS ABOVE	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	acidosis	1-2wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	renal failure	Coma
DUE TO, OR AS A CONSEQUENCE OF (c)	Mesodermal Sarcoma Uterus	18 m

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: Oct 1987, Feb 88	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Mixed Mesodermal Sarcoma	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from Dec 19 88, to Feb 19 89, that (I) (we) last saw the deceased alive on Jan 19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph J. Welch III	DEGREE: M.D ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/22/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph J. Welch III	22e. ADDRESS: 707 Camden Ave	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): MAUSOLEUM	23b. DATE: 2-21-89	23c. NAME OF CEMETERY OR CREMATORY: SPRINGHILL MEMORY	23d. LOCATION CITY OR TOWN: HEBRON	COUNTY: WICOMICO STATE: MD.
24. FUNERAL DIRECTOR NAME: JOLLEY MEMORIAL CHAPEL ADDRESS: RTE. 2, BOX 920 SALISBURY, MD.		25a. DATE REC'D. BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pendelton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

023961 FEB 28 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062 12 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 5

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Thurman Ward Grogan	2a. DATE OF DEATH MONTH / DAY / YEAR	2 11 89	2b. HOUR	M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH / DAY / YEAR	8 15 1914
6. AGE (IN YEARS LAST BIRTHDAY)	74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Todd, N.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Wicomico MD.				
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PGHMC	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Carpenter
12b. KIND OF BUSINESS OR INDUSTRY	Home Impr.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Wicomico	13c. CITY OR TOWN	Salisbury
13d. INSIDE CITY LIMITS? YES [ ] NO [X]		13e. STREET ADDRESS / ZIP CODE	1315 Lexington St. 21801		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Jake Grogan	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Clara Black		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	Army 42-45	16b. SOCIAL SECURITY NO.	215-12-9045
17. INFORMANT	Pebble Jean Grogan	ADDRESS	1315 Lexington St. Salisbury		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ½ hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) emphysema
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: congestive heart failure diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan 18, 19 89 to Feb 11, 19 89, that (I) (we) last saw the deceased alive on Feb 26, 19 89 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE William Nagel DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED 2-13-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. NAGEL, MD

22e. ADDRESS PGHMC Salisbury Md 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2-15-89	Wico. Mem. Park	Salisbury	Wico. Md.
24. FUNERAL DIRECTOR NAME / ADDRESS	Bounds Funeral Home Salisbury, Md.	25a. DATE REC'D. BY REGISTRAR	FEB 13 '89	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

023510 FEB 22 89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06213
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: BETTY	MIDDLE: M	LAST: HAINES	2a. DATE OF DEATH MONTH: 2	DAY: 4	YEAR: 89	2b. HOUR: 12 50 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 8	DAY: 11	YEAR: 26	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico Co. MD.				
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): DEER'S HEAD CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Operator	12b. KIND OF BUSINESS OR INDUSTRY: C+P Telephone				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Westover	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET ADDRESS: Rumbley Star Route, Box 62			
14. FATHER'S NAME FIRST: Arthur	MIDDLE	LAST: Neuman	15. MOTHER'S MAIDEN NAME FIRST: Helen	MIDDLE	LAST: Spurley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-22-0722	17. INFORMANT: Mr Edward H. Haines	ADDRESS: Box 62, Rumbley Star Route Westover, Md 21871			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Small cell Ca of lung + metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-2 19 89 to 2-4 19 89 that (I) (we) last saw the deceased alive on 2-3 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I, (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. HWANG — 22e. ADDRESS: DEER'S HEAD CENTER, Salisbury Md. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/6/89	23c. NAME OF CEMETERY OR CREMATORY: Beechwood	23d. LOCATION CITY OR TOWN: Pr. Anne / COUNTY: Somerset / STATE: Md
24. FUNERAL DIRECTOR NAME / ADDRESS: Hinman Funeral Home, Pr. Anne, Md	25a. DATE RECEIVED BY REGISTRAR: FEB 6 89	25b. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

022114 FEB 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 06214

1. DECEASED NAME (TYPE OR PRINT) FIRST: Burbage	MIDDLE	LAST: Harrison	2a. DATE OF DEATH MONTH DAY YEAR: February 2, 1989	2b. HOUR: 0133 M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: May 28, 1907	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): proprietor	12b. KIND OF BUSINESS OR INDUSTRY: plant nursery	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Worcester	Berlin	YES [X] NO [ ]	211 North Main Street/21811

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
George Alfred Harrison	Olivia Burbage

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		216-18-2950	Billy Esham 214 Broad Street Berlin, Maryland 21811

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
David Walker	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	02/02/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
David Walker, M.D.	H. Gray Reeves Center, Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
burial	02/04/89	Buckingham Presbyterian	Berlin, Worcester, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. Kirk Burbage	108 Williams Street Berlin, Maryland 21811	FEB 7 1989	Meredith Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/removal permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

0-25-389 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2/21/89

89 REG. NO. 062 15

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Lowde	Josephine	Henderson	2 22 89	10:32 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
female	white	April 18, 1904	84 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	PENINSULA GENERAL HOSPITAL	housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 21851

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Worcester	Pocomoke	YES ☐ NO ☒	route 3, box 168A

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Robert		Henderson	Elizabeth	Josephine	(unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		215-62-2480	Pat Johnson	route 3, box 168A Pocomoke City, Md. 21851

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia, Cellulitis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CAD, Dementia, PVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE James J. Carney MD DEGREE Dr. Kozmetsky & Hardy ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ 22c. DATE SIGNED 2/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. CARNEY MD 22e. ADDRESS P.O. Box 640 Pocomoke, Md 21851

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/28/89	Salem Methodist Cem.	Pocomoke Worcester Md.

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Scott S. Milson	Pocomoke City, Md.	MAR 02 '89	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 2

DHMH - 1650M 1/81 (VRA 15, 4)

023765 FEB 22 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06216 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: CARRIE	Middle: H.	Last: HENSHAW	2a. DATE OF DEATH Month Day Year: 2-19-89	2b. HOUR: 3:15A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH Month Day Year: FEB. 02, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO COUNTY MD.		
10. CITY OR TOWN OF DEATH: SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Homemaker		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Crisfield	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 12 W. Main Street, 21817	
14. FATHER'S NAME First: CHARLES	Middle: --	Last: HAGINS	15. MOTHER'S MAIDEN NAME First: MARY	Middle: --	Last: LEWIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-70-7991	17. INFORMANT: Carolyn Sterling	ADDRESS: Main Street Ext'd. Crisfield, MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: DEPRESSION, CHRONIC ABDOMINAL PAIN.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/7 19 84 to 2/19 19 89, that (I) (we) last saw the deceased alive on 2/19 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark Speakemd — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 2/20/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK SPEAKE, M.D. — 22e. ADDRESS: 106 Mt. Vernon Rd. Princess Anne, Md 21853

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 02-21-89	23c. NAME OF CEMETERY OR CREMATORY: Salisbury Crematory	23d. LOCATION CITY OR TOWN: Salisbury	COUNTY: WI STATE: MD
24. FUNERAL DIRECTOR NAME: Bradshaw & Sons	ADDRESS: 306 Main Street Crisfield, MD 21817	25a. DATE REC'D BY REGISTRAR: FEB 22 1989	25b. REGISTRAR'S SIGNATURE: Sheldon Randall	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024105 FEB 2 9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062 17
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 15

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert	MIDDLE: C	LAST: Hernick	2a. DATE OF DEATH MONTH DAY YEAR: Feb 12 89	2b. HOUR: 8:30 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 30, 1938	6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.	
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Graphic Arts	12b. KIND OF BUSINESS OR INDUSTRY: US Gov.'t	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Calvert	13c. CITY OR TOWN: Port Republic	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 3120 North Ave. 20676
14. FATHER'S NAME FIRST MIDDLE LAST: Michael Edward Hernick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Mary Elizabeth Carter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): 1962/1967	16b. SOCIAL SECURITY NO.: 215-34-3397	17. INFORMANT: Elizabeth Mc Clure (daughter)	ADDRESS: Same as #13 A-E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Widespread Cancer of the Bone
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/24 19 89, to 2/12 19 89, that (I) (we) last saw the deceased alive on 2/12 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Benito S. Chan MD — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/12/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BENITO S. CHAN — 22e. ADDRESS: 597-D Riverside Dr. Salisbury MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-16-1989	23c. NAME OF CEMETERY OR CREMATORY: Washington National	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Suitland, Pr. Geo.'s, Md.
24. FUNERAL DIRECTOR NAME: Donald V. Borgwardt — ADDRESS: 4405 Broomes Isl Rd; Port Republic, Md. 20676	25a. DATE REC'D. BY REGISTRAR: FEB 17 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondella	

0 023043 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06218
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: NETTIE; MIDDLE: MAE; LAST: Hill			2a. DATE OF DEATH — MONTH DAY YEAR: January 26, 1989
3. SEX: Female	4. RACE: WHITE	5. DATE OF BIRTH — MONTH DAY YEAR: Oct. 31, 1927	6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): SALIABURY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chicken Vacanation, Poultry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: WICOMICO	13c. CITY OR TOWN: SALISBURY	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: BOX 702, Johnson Road	12b. KIND OF BUSINESS OR INDUSTRY: 2189
14. FATHER'S NAME — FIRST: ERNEST; MIDDLE: F.; LAST: STEELE			15. MOTHER'S MAIDEN NAME — FIRST: ELSIE; MIDDLE: --; LAST: JONES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.: 218-20-6309	17. INFORMANT: Faye Banks	ADDRESS: Box 700 Johnson Road Salisbury, MD 21801	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation
DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1 26, 19 89, to 1 26, 19 89, that (I) (we) last saw the deceased alive on 1 26, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Benjamin H Mueger	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1/27/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 01-31-89	23c. NAME OF CEMETERY OR CREMATORY: WICOMICO MEMORIAL	23d. LOCATION — CITY OR TOWN: SALISBURY; COUNTY: WI; STATE: MD	
24. FUNERAL DIRECTOR — NAME: Holloway Funeral Home	ADDRESS: 501 Snow Hill Rd. Salisbury, MD	25a. DATE REC'D BY REGISTRAR: JAN 31 89	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Rendell	

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

023796 FEB 2 6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06219
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Elaine	MIDDLE	LAST: Holman	2a. DATE OF DEATH MONTH: 2 DAY: 4 YEAR: 89	2b. HOUR: 12 45 PM	
3. SEX: Female	4. RACE: Black	5. DATE OF BIRTH MONTH: MAR DAY: 27, YEAR: 1957	6. AGE (IN YEARS LAST BIRTHDAY): 31 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 510 Isabella St., 21801	
14. FATHER'S NAME FIRST: Stanley	MIDDLE: B.	LAST: Holman	15. MOTHER'S MAIDEN NAME FIRST: Ruth	MIDDLE: —	LAST: Swann
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 183-50-5932	17. INFORMANT: Stanley B. Holman	ADDRESS: P.O. Box 16 Nanticoke, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acquired Immune deficiency syndrome

DUE TO, OR AS A CONSEQUENCE OF (c): Drug addiction

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Skin infection opportunistic infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 1-13 19 89, to 2-4 19 89, that (I) (we) last saw the deceased alive on 2-4 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Constantine J Tan — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 2/4/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CONSTANTINE J TAN — 22e. ADDRESS: 547-D Riverside Dr Salisbury MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 02-06-89	23c. NAME OF CEMETERY OR CREMATORY: Salisbury Crematory	23d. LOCATION CITY OR TOWN: Salisbury	COUNTY: WI STATE: MD
24. FUNERAL DIRECTOR NAME & ADDRESS: Messick Funeral Home P.O. Box 61 Bivalve, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 07 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 2

DHMH - 16 50M 1/81 (VRA 15, 4)

123051 FEB 17 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006220 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): Charles Teubner Hopkins

2a. DATE OF DEATH: 1 27 89 (MONTH DAY YEAR)

2b. HOUR: 11:55 PM

3. SEX: Male

4. RACE: WHITE

5. DATE OF BIRTH: June 18, 1909

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Cabinet Maker

12b. KIND OF BUSINESS OR INDUSTRY: CARPENTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: WICOMICO

13c. CITY OR TOWN: SALISBURY

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 502 W. COLLEGE Ave., 21801

14. FATHER'S NAME: GEORGE WASHINGTON HOPKINS, Sr.

15. MOTHER'S MAIDEN NAME: IRENE MELLIE TEUBNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES

16b. (IF YES, GIVE WAR OR DATES): ARMY

16b. SOCIAL SECURITY NO.: 214-10-7603

17. INFORMANT: Jeanne Hopkins Marvel

ADDRESS: 36 Estaught Av Haddonfield, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cancer of the Lung with Brain metastasis

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M. Shrestha DEGREE: MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 1/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): M. Shrestha, M.D.

22e. ADDRESS: Deer's Head Center, Salisbury, Md. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 01-30-89

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial

23d. LOCATION: CITY OR TOWN: Salisbury COUNTY: WI STATE: MD

24. FUNERAL DIRECTOR: NAME: Holloway Funeral Home ADDRESS: 501 Snow Hill Rd Salisbury, MD

25a. DATE REC'D. BY REGISTRAR: JAN 31 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

024334 FEB 28 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06221
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST LOTTIE MIDDLE Virginia LAST HOWARD
2a. DATE OF DEATH: MONTH 02 DAY 22 YEAR 89
2b. HOUR: 1820 P.M.
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 8 DAY 9 YEAR 1902
6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Pocomoke
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Route #2 Box 261 21851

14. FATHER'S NAME: FIRST MJoseph MIDDLE Corbin LAST Taylor
15. MOTHER'S MAIDEN NAME: FIRST Emma MIDDLE LAST Russell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 213-18-5555
17. INFORMANT: Lee Emma Herz ADDRESS: Rt.#2 Box 261 Pocomoke, Md.21851

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DISSEMINATED HERPES ZOSTER
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PERNICIOUS ANEMIA, PARKINSON'S DISEASE

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 89 to 2/22 19 89, that (I) (we) last saw the deceased alive on 2/22 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did) (did not) view the body after death.
22b. SIGNATURE: Ronald P. Travitz
DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED:
22d. PHYSICIAN'S NAME (TYPE OR PRINT): RONALD P. TRAVITZ MD
22e. ADDRESS: 560 RIVERSIDE DRIVE SALISBURY

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/25/89
23c. NAME OF CEMETERY OR CREMATORY: First Baptist Cem.
23d. LOCATION CITY OR TOWN: Pocomoke COUNTY: Worcester STATE: Md.

24. FUNERAL DIRECTOR NAME: Scott Melson MELSON ADDRESS: PO BOX 64 POCOMOKE Md. 21851
25a. DATE REC'D. BY REGISTRAR: FEB 28 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

022111 FED 88

1 - FOR STATE REGISTRAR

REG. NO. 82 06222

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dewey	MIDDLE:	LAST: HUDSON	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 3, 1989	2b. HOUR: 0610 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 2 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Poultry		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Bishopville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS / ZIP CODE: Rt.1 Box 14 21813	
14. FATHER'S NAME FIRST: Walter	MIDDLE: J.	LAST: Hudson	15. MOTHER'S MAIDEN NAME FIRST: Eva	MIDDLE:	LAST: Turner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 220-34-9279	17. INFORMANT: Laura S. Hudson, Bishopville, Maryland	ADDRESS:	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sepsis + Cardiac failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION: 27 Jan 89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pneumonia	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 27 Jan 89 to 3 Feb 89, that (I) (we) last saw the deceased alive on 3 Feb 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 3 Feb 89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ANDREW J. FOEGASH — 22e. ADDRESS: PGHMC, SALISBURY, MD. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-5-89	23c. NAME OF CEMETERY OR CREMATORY: Bishopville	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bishopville Worcester MD

24. FUNERAL DIRECTOR: Charles W Hearn, Selbyville, Del — 25a. DATE REC'D. BY REGISTRAR: FEB 7 1989 — 25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

024756 MAR 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06223
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alonzo	MIDDLE: Clarence	LAST: JOHNSON	2a. DATE OF DEATH MONTH DAY YEAR: Feb. 8, 1989	2b. HOUR: 12:20 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 2, 1937	6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Mexico	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Construction Worker	12b. KIND OF BUSINESS OR INDUSTRY: Building		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Delaware	13b. COUNTY: Sussex	13c. CITY OR TOWN: Delmar	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 500 Rose Street	
14. FATHER'S NAME FIRST MIDDLE LAST: Claude Johnson	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Alda Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Korean	16b. SOCIAL SECURITY NO.: 525-78-0120	17. INFORMANT ADDRESS: Stephanie Donoway Delmar, DE 19940		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma of Colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one year
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ~~I~~ (this hospital) attended the deceased from 6 Feb., 19 89, to 8 Feb., 19 89, that (I) (~~we~~) last saw the deceased alive on 8 Feb. 1989, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: J. E. Martin	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/8/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): James E. Martin, M.D.	22e. ADDRESS: 145 E. Carroll St., Salisbury, MD.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-10-1989	23c. NAME OF CEMETERY OR CREMATORY: Springhill Memory Gardens	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Hebron Wicomico MD
24. FUNERAL DIRECTOR NAME ADDRESS: Short Funeral Home Delmar, DE 19940	25a. DATE REC'D. BY REGISTRAR: FEB 9 '89	25b. REGISTRAR'S SIGNATURE: [illegible]	

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

024897 MAR -8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR

REG. NO. 89 006224

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and if checked or

024851 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06225 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Vannie	MIDDLE: T.	LAST: Jones	2a. DATE OF DEATH MONTH DAY YEAR: 2 23 89	2b. HOUR: 1350 M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 4 1 1891	6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS.	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Worcester	Pocomoke	YES ☐ NO ☑	Rt. 3 Box 209 21851

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Elias	Washington	Taylor	Sarah		Aydelotte

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		214-74-8258	Richard Jones	Rt. 3 Box 209 Pocomoke, Md. 21851

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Influenza

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from _____, 19 85, to Feb 23, 19 87, that ~~I/we~~ (we) last saw the deceased alive on 2/23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Paul Fleury	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/23/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Paul R Fleury	305 Tenth St Pocomoke City Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/27/89	Remson Methodist Cem.	Pocomoke, Worcester, Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Scott S. Melson	P.O. Box 64 Pocomoke, Md. 21851	MAR 03 1989	Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024855 MAR -3 '89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06226
REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST: Hassola MIDDLE: LAST: King				2a. DATE OF DEATH MONTH DAY YEAR: 02 26 89	2b. HOUR: 0855 M
3. SEX: F	4. RACE: B 2	5. DATE OF BIRTH MONTH DAY YEAR: 11 25 1898	6. AGE (IN YEARS LAST BIRTHDAY): 90 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ~~Washington~~ Wicomico MD.		
10. CITY OR TOWN OF DEATH: Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington Co Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md	Wash	Hag	YES ☑ NO ☐	55 E Washington St

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Marshall Warks King	Fannie (UNK.) (UNK.)	No	203-10-9581	Bette Nicholas 514 Beverly Lane Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic congestive heart failure and chronic lung desease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-25-89, 19____, to 2-26-89, 19____, that (I) (we) last saw the deceased alive on 2-26, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2/26/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Guedenet	

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 1

DHMH - 1650M 1/81 (VRA 15, 4)

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/28/89	Green Lawn Memorial Park	Williamsport Wash., Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Gerald N. Minnich	305 N. Potomac Street Hagerstown, Maryland	FEB 27 '89	Julia Davidson Rendall

023442 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 06227

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Hannah McCormick Kuhn			2a. DATE OF DEATH MONTH DAY YEAR	1-30-89
				2b. HOUR	2:00P M
3. SEX	FEMALE	4. RACE	WHITE	5. DATE OF BIRTH MONTH DAY YEAR	June 14, 1898
6. AGE (IN YEARS LAST BIRTHDAY)	91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	OHIO	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	WICOMICO COUNTY MD.				
10. CITY OR TOWN OF DEATH	SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SALISBURY Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK EOR MOST OF WORKING LIFE)	Merchant
12b. KIND OF BUSINESS OR INDUSTRY	Jewelry				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND	13b. COUNTY	Wicomico	13c. CITY OR TOWN	Salisbury
13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS	CAMDEN Avenue 21801		
14. FATHER'S NAME FIRST / MIDDLE / LAST	WALTER BLAKE McCORMICK	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	CORA ANN WILLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	219-34-4092
17. INFORMANT ADDRESS	ANN K, PURNELL 108 Edinburgh Court Salisbury, MD 21801				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac - respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) cerebral infarct
DUE TO, OR AS A CONSEQUENCE OF (c) dementia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 7/1, 19 88, to 1/30, 19 89, that (I) (we) last saw the deceased alive on ____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM ROBINS, M.D.

22e. ADDRESS RT. 50 & CIVIC AVE., SALSIBURY, MD. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	02-02-89	Parsons Cemetery	Salisbury	WI MD

24. FUNERAL DIRECTOR NAME / ADDRESS	Holloway Funeral Home 501 Snow Hill Rd. Salisbury, MD	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
		FEB 06 89	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

23441 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006223

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
ERNESTINE	MARIE	LACKIE	1	29	89	0600 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	6	6	1918	70 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
FLORIDA	U.S.A.		WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	322 GLEN AVE.	RETIRED	ACCOUNTANT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WICOMICO	SALISBURY	YES ☐ NO ☐	322 GLEN AVE. 21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ERNEST		SALIS	HILDA		ROBERTS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		263-42-7768	James C. Lackie	1202 Fredrick Ave. Salisbury, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) S/P Anterior MI — 2 week

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 89, to January 29, 19 89, that (I) (we) last saw the deceased alive on 1/28, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Paul R Kelly	MD		1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Paul Fleury	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	2/2/89	City Cemetery	Key West	Monroe	Florida

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home P.A.	Salisbury Md.	FEB 02 89	Jake Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

023463 FEB 22 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006229
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MYRA MIDDLE: Waller LAST: LANGRALL				2a. DATE OF DEATH MONTH DAY YEAR: 02-02-89	2b. HOUR: 3:10PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH 11 DAY 28 YEAR 1887		6. AGE (IN YEARS LAST BIRTHDAY): 101 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO COUNTY MD.	
10. CITY OR TOWN OF DEATH: SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Hebron	YES ☐ NO ☐	303 Main St. 21830

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST: James	MIDDLE: A.	LAST: Waller	FIRST: Margaret	MIDDLE:	LAST: Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-----	215-50-0831	Albert J. Bailey	Hebron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) UROSEPSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SENILE DEMENTIA ALZHEIMER'S TYPE, HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-6 19 82 to 2-2 19 89, that (I) (we) last saw the deceased alive on 2-2 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Mark Speakemd	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	02-03-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARK SPEAKE, MD	RT. 50 &CIVIC AVE, SALISBURY, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-6-1989	Parsons Cemetery	Salisbury Wicomico MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bounds Funeral Home	Salisbury, MD	FEB 06 '89	Gina Davidson-Lynch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

0230947 FEB 17 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006230

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Timmie — MIDDLE: — LAST: Lemon

2a. DATE OF DEATH — MONTH: January — DAY: 25 — YEAR: 1989

2b. HOUR: — M

3. SEX: M

4. RACE: Blk

5. DATE OF BIRTH — MONTH: 5 — DAY: 5 — YEAR: 15

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Macon, Miss

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico — MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Wico — 13c. CITY OR TOWN: Fruitland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 213 Dulany Ave. Fruitland Md. 21826

14. FATHER'S NAME — FIRST: Ed — MIDDLE: — LAST: Lemon

15. MOTHER'S MAIDEN NAME — FIRST: Emma — MIDDLE: — LAST: Lemon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): WWII (IF YES, GIVE WAR OR DATES): Army

16b. SOCIAL SECURITY NO.: 287-18-2750

17. INFORMANT — ADDRESS: Mabel Lemon — Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Refractory Hypotension — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Severe CHF

DUE TO, OR AS A CONSEQUENCE OF (c): ASHD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute renal failure

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/20 19__, to 1/25/89 19__, that (I) (we) last saw the deceased alive on 1/25 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Bal Gawel — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Bal Gawel

22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1/31/89

23c. NAME OF CEMETERY OR CREMATORY: Green Acres Cemet.

23d. LOCATION — CITY OR TOWN: Salisbury — COUNTY: Wico — STATE: Md.

24. FUNERAL DIRECTOR — NAME: LEWIS N. WATSON F/H — ADDRESS: West Rd. Salisbury, Md.

25a. DATE REC'D BY REGISTRAR: JAN 30 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner, must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

025249 MAR 14 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06231
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Ruth	Helen	Lewis	2-23-89	8:40 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	Sept 11, 1912	76 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	US		WICOMICO COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY, MD.	SALISBURY NURSING HOME	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 21801

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES XX NO ☐	Rt 50 & Civic Ave

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Gordon		Hall	Sadie		Dunnock

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-07-8376	Monroe Lewis	St.Petersburg,Fl 33710 2375 51st St N

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	2 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	aspiration pneumonia	2 Wks
DUE TO, OR AS A CONSEQUENCE OF (c)	Alzheimer's Disease	2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): L hip fracture 2-6-89

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C Stegman MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	2-23-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CHARLES STEGMAN, M.D.	106 Mt. Vernon Rd., Princess Anne, Md.21853

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/27/1989	Dor Memorial Park	Cambridge Dor Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
THOMAS FUNERAL HOME CAMBRIDGE, MD.	FEB 27 '89	Gloria Davidson-Randall

023960 FEB 2 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06232 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: EDITH MIDDLE: LAPINE LAST: Lipkin				2a. DATE OF DEATH MONTH DAY YEAR: Feb 12, 1989	2b. HOUR: 7 15 a M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: July 31, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Homemaker		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 503 Loblolly Lane, 21801	
14. FATHER'S NAME FIRST: LOUIS MIDDLE: -- LAST: LAPINE			15. MOTHER'S MAIDEN NAME FIRST: JENNY MIDDLE: -- LAST: RUTINBERG		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 076-07-5414	17. INFORMANT: LOUIS SUBURBAN CHAPEL	ADDRESS: 13-01 Broadway Fair Lawn, N.J.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio - Pulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CHF

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cardiac arrythmia. Hypertension. Renal failure.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/30/89, 19____, to 2/12/89, 19____, that (I) (we) last saw the deceased alive on 2/11/89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/12/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): H.R. HEDA	22e. ADDRESS: 614 D EASTERN SHORE Drive SALISBURY, MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 02-15-89	23c. NAME OF CEMETERY OR CREMATORY: Beth Moses Cemetery	23d. LOCATION CITY OR TOWN: Farmingdale COUNTY: Sulf. STATE: N.Y.	
24. FUNERAL DIRECTOR NAME: Holloway Funeral Home ADDRESS: 501 Snow Hill Rd. Salisbury, MD		25a. DATE REC'D. BY REGISTRAR: FEB 13 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

023778 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062333 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: ADELINE	MIDDLE: Rounds	LAST: Livingston	2a. DATE OF DEATH MONTH: February	DAY: 8	YEAR: 1989	2b. HOUR: 2150 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: Nov.	DAY: 11,	YEAR: 1897	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.				
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookkeeper	12b. KIND OF BUSINESS OR INDUSTRY: Battery Co				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	Wicomico	Salisbury	YES ☒ NO ☐	434 Druid Hill Ave 21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
T.	Jackson	Rounds	Kate		Collins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-10-7736	William Martin	434 Druid Hill Ave Salisbury Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral ~~Thrombo~~ Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (c): Atherosclerotic Heart Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Acute myocardial infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/30/89	gangrene 1 great toe R	YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/19 19 89, to 2/8 19 89, that (I) (we) last saw the deceased alive on 2/8 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Philip A Insley Jr	MD	☐ ☐ ☐	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Philip A Insley Jr	145 Carroll Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/11/1989	Parsons Cem	Salisbury Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bounds Funeral Home, Salis, Md.	FEB 10 '89	Gina Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

025385 MAR

Items 18a thu 22a Per M.E. FilmG65 6/19/89 CG

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 006234

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Joanna	Edith	Rangel Lopez

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 2 DAY 22 YEAR 89 — 2b. HOUR —

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 1 YR. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
FEMALE	MEXICAN	AUG 18 1987	1 YRS.				

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 22 YEAR 89 — 2d. HOUR 12:00 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MEXICO	MEXICO		Wicomico County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	NONE	-

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WICOMICO	SALISBURY	YES XX NO ☐	501 EMORY COURT, APT. 104 21801

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
UNKNOWN	ESTELLA RANGEL LOPEZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (ADDRESS)
NO	-	NONE	501 EMORY CT.,APT.104 EVERARDO CASILLAS, SALISBURY, MD 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

1999

IMMEDIATE CAUSE (a) Head injury

Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) _____

DUE TO, OR AS A CONSEQUENCE OF (c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	P.M. 2/22/89 19	Subject allegedly fell

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	Home	501 Emory Ct. Salisbury, Wico Co. Md.

22a. I certify that I took charge of the remains described above, held on Autopsy XX Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide XX Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. Korell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-23-89

VOLUNTEER EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	2-27-89	WICOMICO MEMORIAL PARK	SALISBURY,WICOMICO,MARYLAND

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ZELLER FUNERAL HOME, SALISBURY, MD 21801	MAR 14 1989	Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, PENDING THE RECORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0253 19 MAR 1 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06235
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Lesley Middle: Thomas Last: MARINER	2a. DATE OF DEATH Month: February Day: 27 Year: 1989	2b. HOUR 0600 M	
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH Month: 5 Day: 21 Year: 22	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS; IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Employee University of Maryland	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Va.	13b. COUNTY: Accomack	13c. CITY OR TOWN: Sanford	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 99999			
14. FATHER'S NAME First: Eslie Middle: Mariner Last:	15. MOTHER'S MAIDEN NAME First: Effie Middle: Last: Howard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 219-03-3738	17. INFORMANT ADDRESS: Hilda F. Mariner	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive heart, renal failure Anemia

19a. DATE OF OPERATION: 2/1/89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Renal failure	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/25 19 89 to 2/27 19 89, that (I) (we) last saw the deceased alive on 2/26 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Steven L Crawshaw — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CRAWSHAW — 22e. ADDRESS: 145 E. CARROLL ST. SALISBURY

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Feb 27. 1989	23c. NAME OF CEMETERY OR CREMATORY: Colonial Crematory	23d. LOCATION CITY OR TOWN: Norfolk	COUNTY / STATE: Va.
24. FUNERAL DIRECTOR NAME: Ruby Pop ADDRESS: Funeral Home Temperanceville Va	25a. DATE REC'D. BY REGISTRAR: MAR 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

999999 BP 6

DHMH 16 50M 1/81 (VRA 15, 4)

124757 MAR -7 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06236
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the local registrar in issuing a burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	DANIEL	ERNEST	Matthews	
2a. DATE OF DEATH — MONTH / DAY / YEAR	February	7,	1989	
2b. HOUR	2212 M			
3. SEX	MALE			
4. RACE	WHITE			
5. DATE OF BIRTH — MONTH / DAY, YEAR	April	21,	1916	
6. AGE (IN YEARS LAST BIRTHDAY)	72 YRS.			
IF UNDER 1 YEAR — MONTHS / DAYS				
IF UNDER 24 HRS — HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	SALISBURY			
7b. CITIZEN OF WHAT COUNTRY?	USA			
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]				
9. BALTIMORE CITY OR COUNTY OF DEATH	WICOMICO MD.			
10. CITY OR TOWN OF DEATH	SALISBURY			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PENINSULA GENERAL HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Certified Financial Plannr			
12b. KIND OF BUSINESS OR INDUSTRY				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	MARYLAND			
13b. COUNTY	WICOMICO			
13c. CITY OR TOWN	SALISBURY			
13d. INSIDE CITY LIMITS?	YES [X] NO [ ]			
13e. STREET ADDRESS	112 E. Isabella St., 21801			
14. FATHER'S NAME — FIRST / MIDDLE / LAST	ERNEST	----	Matthews	
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Mary	---	Parker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO			
(IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO.	220-01-2536			
17. INFORMANT	Dorothy Matthews			
ADDRESS	112 E. Isabella St Salisbury, MD			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Post-op (R) carotid endarterectomy; chronic anemia; metastatic prostate carcinoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1989 to Feb. 7, 1989, that (I) (we) last saw the deceased alive on Jan. 11 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Rodney A. Wenrich	DEGREE M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED	2/8/89		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	RODNEY A. WENRICH		
22e. ADDRESS	100 POWER ST. SALISBURY Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	BURIAL	23b. DATE	02-11-89	
23c. NAME OF CEMETERY OR CREMATORY	Springhill Memory			
23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Hebron	WI	MD	
24. FUNERAL DIRECTOR — NAME / ADDRESS	Holloway Funeral Home	501 Snow Hill Rd Salisbury, MD		
25a. DATE REC'D. BY REGISTRAR	FEB 9 '89			
25b. REGISTRAR'S SIGNATURE	Julia Davidson-Rondella			

023045 FEB 17 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006237

1. DECEASED NAME (TYPE OR PRINT): FIRST BENJAMIN MIDDLE LAST McBRIDE Sr
2a. DATE OF DEATH: MONTH 1 DAY 26 YEAR 89
2b. HOUR: 7.15 AM
3. SEX: Male
4. RACE: Black
5. DATE OF BIRTH: MONTH 3 DAY 12 YEAR 1912
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABORER
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 712 Olivia. Street 21801

14. FATHER'S NAME: FIRST William MIDDLE LAST McBride
15. MOTHER'S MAIDEN NAME: FIRST Sarah MIDDLE LAST Stewart
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
16a. (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 220-10-9744
17. INFORMANT: Vernon McBride ADDRESS: 103 Chippewa Blvd Salis MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic lung carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary artery disease

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-3 19 89 to 1-26 19 89, that (I) (we) last saw the deceased alive on 1-25 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: E. Lignos DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 1.26.89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): EVANGELOS LIGNOS M.D.
22e. ADDRESS: MEDICAL CENTER N. #6 SALISBURY

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 1-31-89
23c. NAME OF CEMETERY OR CREMATORY: Green Acres
23d. LOCATION CITY OR TOWN: Salisbury COUNTY: Wico. STATE: MD
24. FUNERAL DIRECTOR NAME: Gladys B. Stewart ADDRESS: West Rd Salis. Md
25a. DATE REC'D. BY REGISTRAR: JAN 31 '89
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

024892 MAR-8 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06238 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Orville	Middle: H.	Last: McCray	
2a. DATE OF DEATH Month Day Year: February 11 1989	2b. HOUR: 0248 M		
3. SEX: Male	4. RACE: Blk	5. DATE OF BIRTH Month Day Year: 1 - 10 - 06	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Frankford, Del	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Minister - Retired	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md	13b. COUNTY: Worchester	13c. CITY OR TOWN: Berlin	13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS: 109 Bowen Circle, Berlin, Md 21811
14. FATHER'S NAME First: Joseph	Middle: H.	Last: McCray	15. MOTHER'S MAIDEN NAME First: Francis — Middle: McCray — Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 221-09-7815	17. INFORMANT — ADDRESS: Fayetta Jarman 531 Flower Street Berlin

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pancreatic Carcinoma.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/27/89 19____, to 2/11/89 19____, that (I) (we) last saw the deceased alive on 2/11/89 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-13-88

22d. PHYSICIAN'S NAME (TYPE OR PRINT): C. Huddleston — 22e. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-15-89	23c. NAME OF CEMETERY OR CREMATORY: Ever Green Cemet.	23d. LOCATION CITY OR TOWN: Berlin	COUNTY: Worchester STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: LEWIS N. WATSON F/H West Rd. - Salisbury	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar		

BP 5

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 06239

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: Russell	Middle:	Last: McGee	2a. DATE OF DEATH Month/Day/Year: 1-14-89	2b. HOUR: 215 AM	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH Month: JUNE Day: 24 Year: 1914	6. AGE (IN YEARS LAST BIRTHDAY): ~~73~~ 74 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): FRANKLINVILLE N.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EITHER, GIVE STREET ADDRESS): RIVERWALK MANOR NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: PAINTER		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: WICOMICO	13c. CITY OR TOWN: SALISBURY	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: 1210 DELAWARE AVE 21801	
14. FATHER'S NAME First: RICHARD Middle: Last: McGEE		15. MOTHER'S MAIDEN NAME First: MARY Middle: Last: SWIFT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 244-18-0449	17. INFORMANT: WILLIAM SMITH	ADDRESS: ADD. SAME AS ABOVE	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Lung with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-2 yrs
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Obstructive Lung Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ~~I~~ (this hospital) attended the deceased from Dec 3 19 88 to Jan 14 19 89, that ~~I~~ (we) last saw the deceased alive on Jan 14 19 89, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Thomas C Hill Jr. M.D. DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS C. Hill Jr — 22e. ADDRESS: Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 1-30-89	23c. NAME OF CEMETERY OR CREMATORY: SALISBURY CREMATORY	23d. LOCATION CITY OR TOWN: SALISBURY COUNTY: WICO. STATE: MD.	
24. FUNERAL DIRECTOR NAME: JOLLEY MEMORIAL CHAPEL ADDRESS: RT. 2, BOX 920 SALISBURY, MD.		25a. DATE REC'D. BY REGISTRAR: FEB 03 89	25b. REGISTRAR'S SIGNATURE: Jane Hamilton Ingalls	

025001 MAR -9

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06240
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harold	MIDDLE: W.	LAST: Mellott	2a. DATE OF DEATH MONTH DAY YEAR: 2-25-89	2b. HOUR: 1415 M		
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 12-17-08	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Big Grove PA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ~~Washington Co~~ Wicomico MD.			
10. CITY OR TOWN OF DEATH: Hag. Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Washington County Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Postman	12b. KIND OF BUSINESS OR INDUSTRY: Postal System			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Pa	13b. COUNTY: Fulton	13c. CITY OR TOWN: Needmore	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: R.D. 1 Bx 330		
14. FATHER'S NAME FIRST: George	MIDDLE: C	LAST: Mellott	15. MOTHER'S MAIDEN NAME FIRST: Louemma	MIDDLE: C	LAST: Hann	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 167-36-1390	17. INFORMANT: Charlotte Brunner	ADDRESS: Warren Pa.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c): ATHEROSCLEROTIC CARDIO-VASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PERIPHERAL VASC DIS.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2.24 19 89 to 2.25 19 89, that (I) (we) last saw the deceased alive on 2.25 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2.25.89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): OTTO ROZA	22e. ADDRESS: 100 LONG MEADOW DRIVE HAGERSTOWN MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: March 1, 89	23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery	23d. LOCATION CITY OR TOWN: McConnellsburg	COUNTY: Fulton STATE: Pa
24. FUNERAL DIRECTOR NAME: Kooser Funeral	ADDRESS: 322 N. Second St. McConnellsburg Pa. 17233	25a. DATE REC'D. BY REGISTRAR: MAR 03 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

023170 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 06241

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Bessie — MIDDLE: — LAST: Merriman

2a. DATE OF DEATH — MONTH: 01 — DAY: 28 — YEAR: 89

2b. HOUR: 7:50 PM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH: May — DAY: 28, — YEAR: 1891

6. AGE (IN YEARS LAST BIRTHDAY): 97 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): TENNESSEE

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.

10. CITY OR TOWN OF DEATH: SALISBURY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): NONE

12b. KIND OF BUSINESS OR INDUSTRY: NONE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: WICOMICO

13c. CITY OR TOWN: SALISBURY

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 104 LENARD DRIVE 21801

14. FATHER'S NAME — FIRST: UNK — MIDDLE: --- — LAST: MERRIMAN

15. MOTHER'S MAIDEN NAME — FIRST: UNK — MIDDLE: — LAST: ---

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217-54-5644

17. INFORMANT: Rev. Stewart Savage — ADDRESS: 104 Lenard Drive Salisbury, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac - respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artery disease

DUE TO, OR AS A CONSEQUENCE OF (c): Mental retardation

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/6 19 87 to 1/28 19 89, that (I) (we) last saw the deceased alive on ____ 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM H. ROBINS, M.D.

22e. ADDRESS: CIVIC AVE. & RT. 50, SALISBURY, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 01-01-89

23c. NAME OF CEMETERY OR CREMATORY: HEBRON CEMETERY

23d. LOCATION — CITY OR TOWN: HEBRON — COUNTY: WI — STATE: MD

24. FUNERAL DIRECTOR — NAME: Holloway Funeral Home — ADDRESS: 501 Snow Hill Road Salisbury, MD

25a. DATE REC'D. BY REGISTRAR: JAN 31 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 0

DHMH - 1650M 1/81 (VRA 15, 4)

24821 MAR -7 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06242 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove continuation papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	Frank		Miller	
2a. DATE OF DEATH — MONTH / DAY / YEAR	February	10,	1989	
2b. HOUR	0236 M			
3. SEX	Male			
4. RACE	Negro			
5. DATE OF BIRTH — MONTH / DAY / YEAR	10-	15-	1912	
6. AGE (IN YEARS LAST BIRTHDAY)	76 YRS.			
IF UNDER 1 YEAR — MONTHS / DAYS				
IF UNDER 24 HRS — HOURS / MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Va.			
7b. CITIZEN OF WHAT COUNTRY?	USA			
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐				
9. BALTIMORE CITY OR COUNTY OF DEATH	WICOMICO MD.			
10. CITY OR TOWN OF DEATH	SALISBURY			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PENINSULA GENERAL HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Laborer			
12b. KIND OF BUSINESS OR INDUSTRY	Truck Driver			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.			
13b. COUNTY	Worcester			
13c. CITY OR TOWN	Pocomoke			
13d. INSIDE CITY LIMITS? YES ☐ NO ☒				
13e. STREET ADDRESS	Rt. 2 Bx. 72 21851			
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Paul		Miller	
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Roxie		Downing	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No			
(IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO.	227-24-1044			
17. INFORMANT	Lillie Miller			
ADDRESS	Rt. 2 Bx. 72 Pocomoke, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Septicemia

DUE TO, OR AS A CONSEQUENCE OF (b): Recurrent Urinary Tract Infection

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Multiple Decubitus Ulcers, with Cardiaplegia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/29 19 89 to 2/10 19 89, that (I) (we) last saw the deceased alive on 2/10 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Benito S. Chan	DEGREE MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/11/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	BENITO S. CHAN	22e. ADDRESS	371-D Riverside Dr. Salisbury

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	2-18-89	
23c. NAME OF CEMETERY OR CREMATORY	Macedonia Bapt. Cem.	23d. LOCATION — CITY OR TOWN / COUNTY / STATE	Westover	Somerset Md.
24. FUNERAL DIRECTOR — NAME / ADDRESS	Samuel G. Savage	New Church, Va.		
25a. DATE REC'D. BY REGISTRAR	FEB 16 '89	25b. REGISTRAR'S SIGNATURE	Gina Davidson-Rankin	

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

024827 MAR -7 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006243 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	WALTER / Edward / MILLS	2a. DATE OF DEATH MONTH / DAY / YEAR	2 / 15 / 89	2b. HOUR	1:30 PM
3. SEX	MALE	4. RACE	BLK	5. DATE OF BIRTH MONTH / DAY / YEAR	3 / 1 / 43
6. AGE (IN YEARS LAST BIRTHDAY)	45 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.
10. CITY OR TOWN OF DEATH	SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	DISABLED 12b. KIND OF BUSINESS OR INDUSTRY:
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md.	13b. COUNTY	Wico	13c. CITY OR TOWN	BERLIN
13d. INSIDE CITY LIMITS? YES ☑ NO ☐		13e. STREET ADDRESS	TRRACR B-11 Bay Berlin Md 21811		
14. FATHER'S NAME FIRST / MIDDLE / LAST	James / Alton / Mills	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Ella / Eliza / Mills		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	←	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	214-46-4421	17. INFORMANT ADDRESS	SONYA Mills

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest — Mins

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Congestive Heart Failure — YRS

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal Failure — YRS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 89, to 2/15 19 89, that (I) (we) last saw the deceased alive on 2/15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Donald M. Wood	DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: 2/15/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): D. M. WOOD MD	22e. ADDRESS: PGHMC	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
B	2-18-89	Coolspring Crem	Fruitland	Wic Md
24. FUNERAL DIRECTOR NAME / ADDRESS	Fooks F/H. P.O.B. 574 Salis.	25a. DATE REC'D. BY REGISTRAR	FEB 16 '89	25b. REGISTRAR'S SIGNATURE

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] upon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

23464 FEB 22 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06244
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ERNEST	MIDDLE: WILLIAM	LAST: Moore SR.	2a. DATE OF DEATH MONTH: February	DAY: 1	YEAR: 1989
2b. HOUR: 2230 M					
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: July	DAY: 21	YEAR: 1923	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Trenton, N.J.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrical Eng.	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Civic Ave. & Rt. 50	
14. FATHER'S NAME FIRST: William	MIDDLE	LAST: Moore	15. MOTHER'S MAIDEN NAME FIRST: Jennie	MIDDLE	LAST: Shotton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 180-18-8412	17. INFORMANT: William Moore	ADDRESS: 701 Lakeside Dr. Salisbury, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident.
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-26-89

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-7-89 to 2-1-89, that (I) (we) last saw the deceased alive on 2-1-89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C. Stegman — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2-2-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES STEGMAN

22e. ADDRESS: PRINCESS ANNE, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-3-1989	23c. NAME OF CEMETERY OR CREMATORY: Parsons Cem.	23d. LOCATION CITY OR TOWN: Salisbury	COUNTY: Wicomico STATE: Md.
24. FUNERAL DIRECTOR NAME: Bounds Funeral Home	ADDRESS: Salisbury, Md	25a. DATE REC'D. BY REGISTRAR: FEB 03 '89	25b. REGISTRAR'S SIGNATURE: Gene Davidson-Randall	

BP 5

DHMH - 16 50M 1/81 (VRA 15, 4)

023047 FEB 17 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06245 S
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Bertha Middle: Melvin Last: MORRIS			2a. DATE OF DEATH Month Day Year: JANUARY 25 1989	2b. HOUR: 1023 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month Day Year: Feb. 16, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Self
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia	13b. COUNTY: Accomack	13c. CITY OR TOWN: Chincoteague	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: Ridge Road 23336
14. FATHER'S NAME First Middle Last: William E. Melvin, Jr.		15. MOTHER'S MAIDEN NAME First Middle Last: Isabelle Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 230-12-2065	17. INFORMANT ADDRESS: Thomas Morris, Chincoteague, Virginia		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive pulmonary Embolus
DUE TO, OR AS A CONSEQUENCE OF (b): Gas Gangrene of the abdominal wall
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Massive obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/16/89 19___ to 1/25/89 19___, that (I) (saw) last saw the deceased alive on 1/25/89 19___ and that in (my) (opinion) death occurred on the date and hour and from the causes stated above. (I) (saw) (did) (did not) view the body after death.

22b. SIGNATURE: Charles L Radcliffe DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 1/25/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles L Radcliffe
22e. ADDRESS: PO Box 2636 Salisbury MD 21801

23a. BURIAL, CREMATION, REMOVAL: Burial	23b. DATE: 1-29-89	23c. NAME OF CEMETERY OR CREMATORY: Thornton Cemetery	23d. LOCATION CITY OR TOWN: Chincoteague	COUNTY: Virginia STATE
24. FUNERAL DIRECTOR NAME / ADDRESS: Constance Selby Corbin, Chincoteague Va	25a. DATE REC'D. BY REGISTRAR: FEB 01 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 2

DHMH - 1650M 1/81 (VRA 15, 4)

025316 MAR 16 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06246 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Denise	MIDDLE: H.	LAST: Morris	2a. DATE OF DEATH MONTH DAY YEAR: 2-21-1989	2b. HOUR: 4:27 PM	
3. SEX: F.	4. RACE: W.	5. DATE OF BIRTH MONTH DAY YEAR: 12 3 1923	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO COUNTY MD.		
10. CITY OR TOWN OF DEATH: SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETd.	12b. KIND OF BUSINESS OR INDUSTRY: LIBRARIAN		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: VA.	13b. COUNTY: ACCOMACK	13c. CITY OR TOWN: ACCOMAC	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: Rt. 13	99999
14. FATHER'S NAME FIRST: LOUIS	MIDDLE: HELMRICH	LAST	15. MOTHER'S MAIDEN NAME FIRST: DINA	MIDDLE: JOSEPHINE	LAST: GAUCHAT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 226-36-5065	17. INFORMANT: Mrs. Sandra S. Mosley	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

DUE TO, OR AS A CONSEQUENCE OF (b): Dehydration — 1 WEEK.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/29 19 85 to 2/21 19 89, that (I) (we) last saw the deceased alive on 2/21 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Mark Speake M.D.	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑	22c. DATE SIGNED: 2/22/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MARK SPEAKE, M.D.	22e. ADDRESS: 106 Mt. Vernon Rd., Princess Anne, Md. 21853	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-25-89	23c. NAME OF CEMETERY OR CREMATORY: Edge Hill	23d. LOCATION CITY OR TOWN: Accomac / COUNTY: Accomack / STATE: VA.	
24. FUNERAL DIRECTOR NAME: Madelyn Lilliston	ADDRESS: Accomac, VA.	25a. DATE REC'D. BY REGISTRAR: MAR 16 1989	25b. REGISTRAR'S SIGNATURE: Julia Davison-Rodgers	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1650M 1/81 (VRA 15, 4)

25252 MAR 14 89

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the case referred to the Office of the Chief Medical Examiner.

BP 13

DHMH - 16 50M 1/81 (VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006247

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
George	B.	Nabb, Jr.	February 25, 1989	0455 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	Cauc.	04- 07-1909	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Wicomico MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	farmer	dairy

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Dorchester	Cambridge	YES ☐ NO ☒	RFD # 2, N. Yarmouth Farm 21613

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	B.	Nabb, Sr	Hattie	unk.	Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
Yes.	WW II	217361100	(wife) Mrs. Georgia Nabb, same as #13	zip: 21613

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bleeding ulcer, ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/24 19 89 to 2/25 19 89, that (I) (we) last saw the deceased alive on 2/24 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
R Layton S	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-25-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C. R. Layton	PCHMC. Box 339 Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY
Burial	2-28-1989	East New Market Cem	EastNewMarket, Dorchester MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Curran Funeral Home, Cambridge, MD 21613	308 High Street	FEB 28 '89	Lydia Davidson-Randall

024963 MAR 8 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 REG. NO. 062483

1. DECEASED NAME (TYPE OR PRINT): Raymond Edward Nichols Sr.

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ — MONTH 2/20 YEAR 19 89 — 2b. HOUR 2100 M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 05 DAY 04 YEAR 1921

6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YR. MONTHS / DAYS — IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH Feb DAY 21 YEAR 19 89 — 2d. HOUR 0115 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware

7b. CITIZEN OF WHAT COUNTRY?: U.S.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 312 Maple Way

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic

12b. KIND OF BUSINESS OR INDUSTRY: Self-Emp.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Wicomico

13c. CITY OR TOWN: Salisbury

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 312 Maple Way 21801

14. FATHER'S NAME — FIRST Will MIDDLE LAST Nichols

15. MOTHER'S MAIDEN NAME — FIRST Sally MIDDLE LAST Hitchens

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes (IF YES, GIVE WAR OR DATES): WW II

16b. SOCIAL SECURITY NO.: 219-05-3944

17. INFORMANT — ADDRESS: Grace Nichols — same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive-Arteriosclerotic Cardio-

DUE TO, OR AS A CONSEQUENCE OF (b): vascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Thomas C Hill Jr. M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2/21/89

EXAMINER'S NAME (TYPE OR PRINT): Thomas C. Hill Jr., M.D. ADDRESS: Pine Bluff Rd, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2-24-89

23c. NAME OF CEMETERY OR CREMATORY: Springhill Mem. Gdns

23d. LOCATION CITY OR TOWN: Hebron COUNTY: — STATE: Md

24. FUNERAL DIRECTOR NAME AND ADDRESS: Bounds Funeral Home, Salisbury, Md

25a. DATE REC'D. BY REGISTRAR: FEB 22 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DHMH 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 12/4

DHMH - 17 (VR A15 ME (5))

022249 FEB-9 89

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06249 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. If the medical examiner must be notified at once. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trouble, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: FLORENCE	MIDDLE: S	LAST: NORRIS	2a. DATE OF DEATH MONTH: February	DAY: 3	YEAR: 1989
2b. HOUR: 1132 M					
3. SEX: F	4. RACE: W	5. DATE OF BIRTH MONTH: 2	DAY: 9	YEAR: 19	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia	13b. COUNTY: Northampton	13c. CITY OR TOWN: Exmore	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 9999	
14. FATHER'S NAME FIRST: Arthur	MIDDLE: S.	LAST: Grant	15. MOTHER'S MAIDEN NAME FIRST: Suzanne	MIDDLE: M.	LAST: Grant
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	IF YES, GIVE WAR OR DATES:	16b. SOCIAL SECURITY NO.: 120-03-3376	17. INFORMANT ADDRESS: Nancy J. Stern		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): - "D.I.C" — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 Hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Mitral Valve Replacement -
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Mitral Valve Replacement

19a. DATE OF OPERATION: 2-2-89	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Mitral Stenosis	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: N.W. Todd	DEGREE: M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-3-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): N. W. Todd	22e. ADDRESS: Med Ctr. West. Salisbury, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 2/5/89	23c. NAME OF CEMETERY OR CREMATORY: Colonial	23d. LOCATION CITY OR TOWN: Norfolk, Va.	COUNTY / STATE
24. FUNERAL DIRECTOR NAME: N. Dale Fox	ADDRESS: Chincoteague, Virginia	25a. DATE REC'D. BY REGISTRAR: FEB 7 1989	25b. REGISTRAR'S SIGNATURE: [signature]	

BP 999999

DHMH - 1650M 1/81 (VRA 15, 4)

0248911 MAR -8 '89

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06250
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or there is any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Robert MIDDLE: LIONEL LAST: O'Connor				2a. DATE OF DEATH MONTH: Feb DAY: 16 YEAR: 1989	2b. HOUR: 7:50 A M
3. SEX: Male	4. RACE: WHITE	5. DATE OF BIRTH MONTH: Jan. DAY: 22, YEAR: 1919	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR MONTHS: DAYS:	IF UNDER 24 HRS HOURS: MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): IRELAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Dear's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Teacher Education	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: WORCESTER	13c. CITY OR TOWN: OCEAN CITY	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: Box 214 13403 Coastal HIGHWAY 21842	
14. FATHER'S NAME FIRST: DANIEL MIDDLE: CORNEILIUS LAST: O'CONNOR			15. MOTHER'S MAIDEN NAME FIRST: ANN MIDDLE: -- LAST: McElroy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES-Army (IF YES, GIVE WAR OR DATES): WWII		16b. SOCIAL SECURITY NO.: 113-07-1580	17. INFORMANT: Arthur O'Connor	ADDRESS: Schlehdornsteig 13 1000 Berlin 38, Ger- many	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of The Lung

DUE TO, OR AS A CONSEQUENCE OF: Brain metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): C.O.P.D.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2-14 19 89, to 2-16 19 89, that (I) (we) last saw the deceased alive on 2-16 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Elsa M. Goris M.D	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	22c. DATE SIGNED: 2-16-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELSA M. GORIS	22e. ADDRESS:	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 02-17-89	23c. NAME OF CEMETERY OR CREMATORY: Salisbury Crematory	23d. LOCATION CITY OR TOWN: Salisbury COUNTY: WI STATE: MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: Holloway Funeral Home, PA 501 Snow Hill Salisbury, MD		25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Josie Davidson-Pondelle	

BP 12

DHMH - 16 50M 1/81 (VRA 15, 4)

024577 MAR-3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06251
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Elwood	Middle: M.	Last: Pilchard	2a. DATE OF DEATH Month: February	Day: 18	Year: 1989
2b. HOUR: 0900 M					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month: September	Day: 11,	Year: 1910	
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS	IF UNDER 1 YEAR Months:	Days:	IF UNDER 24 HRS Hours:	Min.:	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Chicken		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Girdletree	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: Rt 1 - Box 53 / 21829	
14. FATHER'S NAME First: John	Middle: A.	Last: Pilchard	15. MOTHER'S MAIDEN NAME First: Myrtie	Middle:	Last: Holland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -----	16b. SOCIAL SECURITY NO.: 219 36 5163	17. INFORMANT ADDRESS: Margaret C. Pilchard, Girdletree, Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Renal Failure

DUE TO, OR AS A CONSEQUENCE OF (c): Adenocarcinoma of the Colon

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION: 11/23/88	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Colon Carcinoma Resection	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip A Insley II MD — DEGREE — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Philip A Insley Jr

22e. ADDRESS: 145 Carroll Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/21/89	23c. NAME OF CEMETERY OR CREMATORY: Springhill Methodist	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Girdletree, Maryland	
24. FUNERAL DIRECTOR NAME / ADDRESS: Norman F. Dennis, Snow Hill, Maryland	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP 6

DHMH - 1650M 1/81 (VRA 15, 4)

124865 MAR -9 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06252
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Bertha	H.	Powell	February	16,	1989	2005 M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	Sept.	23,	1903	85 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.		WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	PENINSULA GENERAL HOSPITAL	Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Somerset	Pr. Anne	YES ☑ NO ☐	Beckford Avenue, 21853

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Thomas		Heath	Louisianna		Messick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-16-9355	Mrs. Martha Powell	Princess Anne Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIO RESPIRATORY ARREST	IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF (b)	ISCHEMIC ENCEPHALOPATHY	1 WEEK
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): SMALL BOWEL OBSTRUCTION, INCISIONAL HERNIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/8, 19 89, to 2/16, 19 89, that (I) (we) last saw the deceased alive on 2/8, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Mark Speckhard MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/8/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 19, 1989	Marokin Presbyterian	Princess Anne	Somerset	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hinman Funeral Home	Pr. Anne, Md 21853	FEB 21 89	Julia Davidson-Randall

024296 FEB 29 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06253
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: HOWARD	MIDDLE: D.	LAST: POWELL	2a. DATE OF DEATH MONTH DAY YEAR: 02-25-89	2b. HOUR: 12:15 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 13, 1911	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Employee	12b. KIND OF BUSINESS OR INDUSTRY: Maryland State Highway		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Marion	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt. 1 - Box 8 (21838)	
14. FATHER'S NAME FIRST: Lorenzo	MIDDLE: Q	LAST: Powell	15. MOTHER'S MAIDEN NAME FIRST: Hettie	MIDDLE:	LAST: Bailey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): W. W. II	16b. SOCIAL SECURITY NO.: 219-36-6405	17. INFORMANT: Lee Powell	ADDRESS: 305 Hall Dr. - Salisbury, MD (21801)	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac - Respiratory arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes
DUE TO, OR AS A CONSEQUENCE OF (c): Senile degeneration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/17 19 89 to 2/25 19 89, that (I) (we) last saw the deceased alive on 2/7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William R Robins — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 3/6/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM ROBINS, MD — 22e. ADDRESS: U.S. RT. 50 & CIVIC AVE. SALISBURY, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/28/89	23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cemetery	23d. LOCATION CITY OR TOWN: Marion	COUNTY: Somerset STATE: MD
24. FUNERAL DIRECTOR NAME: Bradshaw & Sons ADDRESS: Crisfield, MD 21817			25a. DATE REC'D BY REGISTRAR: MAR 1 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

23439 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06254
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Maggie — MIDDLE: Elizabeth — LAST: Briddell Purnell

2a. DATE OF DEATH — MONTH DAY YEAR: February 2, 1989

2b. HOUR: 633a M

3. SEX: Female

4. RACE: Black

5. DATE OF BIRTH — MONTH DAY YEAR: 3 2 24

6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.

10. CITY OR TOWN OF DEATH: SALISBURY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired-laborer

12b. KIND OF BUSINESS OR INDUSTRY: Hotel

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Worcester

13c. CITY OR TOWN: Berlin

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: 211 Maple Avenue/21811

14. FATHER'S NAME — FIRST: Lee — MIDDLE — LAST: Briddell

15. MOTHER'S MAIDEN NAME — FIRST: Mary — MIDDLE: Jarmon — LAST: Ayres

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES): ---------

16b. SOCIAL SECURITY NO.: 213-14-7886

17. INFORMANT — ADDRESS: George T. Purnell/same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic Encephalopathy

DUE TO, OR AS A CONSEQUENCE OF (b): Cardiac / Cirrhosis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

End-Stage Renal Disease 2° to Diabetic Nephropathy, Diabetes Mellitus

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/23 19 89 to 2/2 19 89 that (I) (we) last saw the deceased alive on Feb. 2 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Benito S. Chan — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BENITO S. CHAN

22e. ADDRESS: 5F7-D Riverside Dr. Salisbury MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 2/6/89

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

23d. LOCATION — CITY OR TOWN: Berlin — COUNTY: Worcester — STATE: Maryland

24. FUNERAL DIRECTOR — NAME: Jolley Memorial Chapel — ADDRESS: Rt.#2, Box 920, Jersey RD Salisbury, MD 21801

25a. DATE REC'D. BY REGISTRAR: FEB 03 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Fowler

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 6

DHMH - 16 50M 1/81 (VRA 15, 4)

023468 FEB 22

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06255
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: HARLEY	MIDDLE: F.	LAST: RECORDS, Jr	2a. DATE OF DEATH MONTH: February	DAY: 15	YEAR: 89	2b. HOUR: 1:50 PM
3. SEX: MALE	4. RACE: CAUC	5. DATE OF BIRTH MONTH-DAY-YEAR: 2-8-23	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DELAWARE	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.			
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Commerical Rep.	12b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: DELAWARE	13b. COUNTY: SUSSEX	13c. CITY OR TOWN: BRIDGEVILLE	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS / ZIP CODE: 309 MARKET STREET - 19933		
14. FATHER'S NAME FIRST: Harley	MIDDLE: F.	LAST: Records, Sr.	15. MOTHER'S MAIDEN NAME FIRST: Leva	MIDDLE	LAST: Morris	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 222-10-9347	17. INFORMANT: Clara T. Records-	ADDRESS: 309 Market Street Bridgeville, DE 19933		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiogenic Shock	HRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial Infarction	HRS
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized Arteriosclerosis	YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 89 to 2/15 19 89 that (I) (we) last saw the deceased alive on 2/15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Donald M. Wood DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑

22c. DATE SIGNED: 2/15/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DONALD M. WOOD

22e. ADDRESS: PHMC Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Feb.18,1989	Bridgeville Cemetery	Bridgeville, Sussex, Delaware

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard E. Hardesty	202 Laws St.- Bridgeville, Delaware	FEB 21 1989	Della Davidson-Kendall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

023775 FEB 2 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06256
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lottie	MIDDLE: B.	LAST: RILEY	2a. DATE OF DEATH MONTH DAY YEAR: February 9, 1989	2b. HOUR: 0645 M	
3. SEX: FEMALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: November 18, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Worcester	Snow Hill	YES ☒ NO ☐	305 S. Morris St. / 21863

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Clayton		Bromley	Myrtle		Beauchamp

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-----	216 10 6466	M. Thomas Riley Jr., Snow Hill, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b): COPD
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4-5 yrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): cor pulmonale

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-7-88 to 2-9-89, that (I) (we) last saw the deceased alive on 2-7-89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C Stegman	MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-9-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles Stegman, Md. 22e. ADDRESS: Princess Anne, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/12/89	Christian	Snow Hill, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Norman F. Dennis, Snow Hill, Maryland	FEB 10 '89	Julia Davidson-Randall

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

023949 FEB 28 89 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06257 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: John	MIDDLE: Emerson	LAST: SauerhoFF	2a. DATE OF DEATH MONTH DAY YEAR: 2 17 89	2b. HOUR: 1 25 A M
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Oct 4, 1897	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Businessman	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 910 Riverside Drive 21801

14. FATHER'S NAME FIRST: William	MIDDLE: J.	LAST: Sauerhoff	15. MOTHER'S MAIDEN NAME FIRST: Ruth / MIDDLE / LAST: Eskridge

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW I	16b. SOCIAL SECURITY NO.: 578-46-7380	17. INFORMANT ADDRESS: Thelma R. Sauerhoff Item # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7'8 hours
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/16 19 89, to 2/17 19 89, that (I) (we) last saw the deceased alive on 2/17 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles B Silvia Jr	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 2/17/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles B. Silvia Jr. MD		22e. ADDRESS: PGHMC	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/19/1989	23c. NAME OF CEMETERY OR CREMATORY: Old Trinity Church	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Church Creek Dor. Md.	
24. FUNERAL DIRECTOR: THOMAS FUNERAL HOME CAMBRIDGE, MD.		25a. DATE REC'D. BY REGISTRAR: FEB 23 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 1650M 1/81 (VRA 15, 4)

022929 FEB 13 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 006253
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): First Herman; Middle F.; Last Short, Jr.

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] Month/Day/Year 2-4-89 — 2b. HOUR

3. SEX: male — 4. RACE: white — 5. DATE OF BIRTH: 9/25/1958 — 6. AGE (IN YEARS LAST BIRTHDAY): 30 YRS. — IF UNDER 1 YR. MONTHS/DAYS — IF UNDER 24 HRS. HOURS/MIN.

2c. DATE PRONOUNCED DEAD: 2-4-89 — 2d. HOUR: 3:31 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] Sep. XX

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.

10. CITY OR TOWN OF DEATH: Salisbury — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): farmer — 12b. KIND OF BUSINESS OR INDUSTRY: farming

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Delaware — 13b. COUNTY: Sussex — 13c. CITY OR TOWN: Millsboro — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS: Rt. 3 Box 216B 99999

14. FATHER'S NAME: First Herman; Middle F.; Last Short Sr.

15. MOTHER'S MAIDEN NAME: First Virginia; Middle Louise; Last Mitchell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 221-66-9124

17. INFORMANT: Herman F. Short Sr. — ADDRESS: Rt. 3 Box 216B Millsboro, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple injuries — 8150
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [XX] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY: HOUR A.M. MONTH DAY YEAR 2:25AM 2-4-89

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/fixed object collision

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX]

21e. PLACE OF INJURY (AT HOME, STREET, FARM, ETC.): road

21f. LOCATION: STREET Delaware Rt. 26, ½ CITY OR TOWN mi. E. of Gumboro, DE COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [XX], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Charles P. Kokes — TITLE (SPECIFY): Acting Deputy Chief M.D. MEDICAL EXAMINER — DATE SIGNED: 2-4-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. — ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 2/9/89 — 23c. NAME OF CEMETERY OR CREMATORY: Short Family Cem. — 23d. LOCATION CITY OR TOWN: Millsboro, Delaware COUNTY STATE

24. FUNERAL DIRECTOR: Richard T. Watson — ADDRESS: Millsboro, Delaware — 25a. DATE REC'D. BY REGISTRAR: FEB 13 1989 — 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

16 99999 BP

07-84 25M

DHMH 17 (VR A15 ME (5))

023046 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062599
REG. NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Gilbert	L.	Smith	January	28	1989 / M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	02	11	1907	81 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Wicomico MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	213 S. Clairmont Dr.	Court Recorder	Judicial Court

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	213 S. Clairmont 21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Thomas	J.	Smith	Ava		Washburn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-------	218-20-6613	Nellie Brown	Fruitland, Maryland 21826

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio pulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James A. Cockey, M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James A. Cockey, M.D.	100 Power St. Salisbury, Maryland 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1-30-1989	Parsons Cemetery	Salisbury Wicomico MD

24. FUNERAL DIRECTOR (NAME)	(ADDRESS)	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
BOUNDS FUNERAL HOME	SALISBURY, MARYLAND	JAN 31 89	

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

023794 FEB 26 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06260 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST	MIDDLE	LAST	2a. DATE OF DEATH — MONTH	DAY	YEAR	2b. HOUR
GLORIA	EVELYN	SMITH	2	3	89	1018 P M

3. SEX	4. RACE	5. DATE OF BIRTH — MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR — MONTHS / DAYS	IF UNDER 24 HRS — HOURS / MIN.
FEMALE	WHITE	DEC. 22, 1908	80 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Puerto Rico	USA		WICOMICO MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
SALISBURY	PENINSULA GENERAL HOSPITAL	Retired Waitress	Food

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
DELAWARE	SUSSEX	Millsboro	YES ☐ NO ☐	Rt. #3, Box 19, 19966

14. FATHER'S NAME — FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME — FIRST	MIDDLE	LAST
ROSS	---	DAVIS	CAROLYN	-----	(UNK)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		156-07-5169	Roy Donald Young	Rt. #3, Box W19 Millsboro, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 1/31 19 89 to 2/3 19 89, that (I) (we) last saw the deceased alive on 2/3 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Jeffrey Wieland MD		2/3/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jeffrey Wieland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
BURIAL	02-06-89	Wicomico Memorial	Salisbury WI MD

24. FUNERAL DIRECTOR — NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home	500 SNOW HILL RD Salisbury, MD	FEB 07 '89	Julia Davidson-Randall

BP 6

DHMH 16 50M 1/81 (VRA 15, 4)

23171 FEB 17 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

89 06261 REG. NO.

1. DECEASED NAME (TYPE OR PRINT): Helen (FIRST) Louise (MIDDLE) Smith (LAST)

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH 1 DAY 28 YEAR 19 89

2b. HOUR 0100 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: MONTH 10 DAY 15 YEAR '20

6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD: MONTH Jan DAY 29 YEAR 19 89

2d. HOUR 1305 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 702 Taylor St., Apt 73

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Nurses-aide

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Wicomico

13c. CITY OR TOWN: Salisbury

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 702 Taylor St., Apt. 73 21801

14. FATHER'S NAME: Charles (FIRST) William (MIDDLE) Henman (LAST)

15. MOTHER'S MAIDEN NAME: Viola (FIRST) Lowell (MIDDLE) Langmaid Adkins (LAST)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 182-20-2951

17. INFORMANT ADDRESS: Helen Moran, P.o Box 358 Fruitland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

Diabetes Mellitus, Chronic Renal Insufficiency

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Thomas C Hill Jr. M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 1/30/89

EXAMINER'S NAME (TYPE OR PRINT): Thomas C. Hill Jr. M.D. ADDRESS: Pine Bluff Rd., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 02-01-89

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial

23d. LOCATION CITY OR TOWN: Salisbury COUNTY: WI STATE: MD

24. FUNERAL DIRECTOR NAME: Holloway Funeral Home ADDRESS: 501 Snow Hill Rd Salisbury, MD

25a. DATE REC'D. BY REGISTRAR: JAN 31 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 5

DHMH - 17 (VR A15 ME (5))

23050 FEB 17 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06262 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: JEAN	MIDDLE: ELLIOTT	LAST: SMITH	2a. DATE OF DEATH MONTH DAY YEAR: January 26 1989	2b. HOUR: M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: Jan. 30, 1926	6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1008 HAYES AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MARYLAND	WICOMICO	SALISBURY	YES [ ] NO [ ]	1008 Hayes Ave. ,21801

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
THOMAS / -- / ELLIOTT	UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	NAVY	215-26-2793	Charles Franklin Smith	1008 Hayes Ave Salisbury, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma of Stomach with metastases.	4 mos.
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
10/11/88	CA Stomach	YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 10/3 19 88 to 1/22 19 89, that (I (we) lost sow the deceased olive on 1/22 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
William P. Sadler	M.D.	[ ] [X] [ ]	1/27/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
CREMATION	01-31-89	Salisbury Crematory	Salisbury WI MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral HOme 501 Snow Hill Rd. Salisbury, MD	JAN 31 '89	Julia Davidson-Randall

BP 10

DHMH - 16 50M 1/81 (VRA 15, 4)

023444 FEB 2 '89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006263
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Marie	MIDDLE: Emma	LAST: Smullen	2a. DATE OF DEATH MONTH DAY YEAR: January 31, 1989	2b. HOUR: 1910 M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug. 19, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner	12b. KIND OF BUSINESS OR INDUSTRY: Nursing Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Delmar	YES ☐ NO ☒	RD #3 Box 41 21875

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Davis A. Lloyd	Radie Blades

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	----	219-07-7749	Earl L. Smullen	RD #3 Bos 41 Delmar, MD 21875

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial failure

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis CA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Small bowel obstruction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
1/26/89	Small bowel obstruction	YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 1/26 19 89 to 1/31 19 89, that (I) (we) last saw the deceased alive on 1/31 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Walter Pleasanton	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1/31/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-4-1989	Smullen Cemetery	Snowhill Worcester Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Short Funeral Home Delmar, DE 19940	FEB 02 '89	Julia Davidson-Randall

BP 4

DHMH - 1650M 1/81 (VRA 15, 4)

025166 MAR 13 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006264
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Lela B. SNEADE			2a. DATE OF DEATH MONTH DAY YEAR	2-26-89
2b. HOUR	805 PM				
3. SEX	Female	4. RACE	Caucasian	5. DATE OF BIRTH MONTH DAY YEAR	4 16 03
6. AGE (IN YEARS LAST BIRTHDAY)	85 YRS	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	USA	7b. CITIZEN OF WHAT COUNTRY?	Somerset	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Wicomico MD.				
10. CITY OR TOWN OF DEATH	SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	RIVERWALK MANOR Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Homemaker
12b. KIND OF BUSINESS OR INDUSTRY	N/A				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	Somerset	13c. CITY OR TOWN	Rhodes Point
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS	Box 37 / 21858			
14. FATHER'S NAME FIRST / MIDDLE / LAST	CHARLES H. BRADSHAW	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	MARY Amanda Hoffman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	214-30-7861
17. INFORMANT ADDRESS	Hilda E. Tyler - same as 13 abcde				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that ☒ (this hospital) attended the deceased from 6/18 19 87 to 2/26 19 89, that ☒ (we) last saw the deceased alive on 2/26 19 89, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	Thomas C Hall Jr. M.D	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED 2/27/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	THOMAS C. HALL JR	22e. ADDRESS	108 Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	03-02-89	23c. NAME OF CEMETERY OR CREMATORY: Rhodes Pt. Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Rhodes Point - Somerset - MD			
24. FUNERAL DIRECTOR NAME / ADDRESS	Bradshaw & Sons -- Crisfield, MD 21817	25a. DATE REC'D BY REGISTRAR	MAR 6 - 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024530 MAR - 2 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06265
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Paige	MIDDLE: C	LAST: Spence	2a. DATE OF DEATH MONTH: 02	DAY: 15	YEAR: 89
2b. HOUR	1:30 PM					
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH: 12	DAY: 16	YEAR: 44
6. AGE (IN YEARS LAST BIRTHDAY)	44 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Virginia	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		
9. BALTIMORE CITY OR COUNTY OF DEATH	Wicomico MD.					
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Holly Farms	12b. KIND OF BUSINESS OR INDUSTRY: Poultry
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Va.	13b. COUNTY	Accomack	13c. CITY OR TOWN	Tasley	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS	Bus. Rt. 13	99999				
14. FATHER'S NAME FIRST	Charlie	MIDDLE: C.	LAST: Spence	15. MOTHER'S MAIDEN NAME FIRST	Beatrice	MIDDLE: Hickman LAST: Spence
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	224-60-8060	
17. INFORMANT	Sylvia Spence	ADDRESS	- Tasley, Va. 23441			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Head & Neck Cancer
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 89 to 2/15 19 89, that (I) (we) last saw the deceased alive on 2/15 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED 2-15-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID E. COHAN, MD
22e. ADDRESS 145 E. CARROLL ST. SALISBURY, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	2/17/89	Mt. Holly Cemetery	Onancock	Accomack Va.
24. FUNERAL DIRECTOR NAME	Tom Williams	ADDRESS	Onancock, Virginia	
25a. DATE REC'D. BY REGISTRAR	FEB 24 1989	25b. REGISTRAR'S SIGNATURE	Jackie Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

BP

DHMH - 66 50M 1/81 (VRA 15, 4)

024890 MAR -8 09

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06266 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use with the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Mary	MIDDLE: Belle	LAST: Spicer	2a. DATE OF DEATH MONTH DAY YEAR: February 5, 1989	2b. HOUR: 1330 M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: March 19, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.			
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: -			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Delaware	13b. COUNTY: Sussex	13c. CITY OR TOWN: Laurel	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 102 Eighth Street/19956		
14. FATHER'S NAME FIRST: Perry	MIDDLE	LAST: Waller	15. MOTHER'S MAIDEN NAME FIRST: Elinor	MIDDLE	LAST: Robinson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 216-10-8775A	17. INFORMANT: Gordy Collins	ADDRESS: 206 State Street, Sharptown, MD 21861		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Senile Dementia — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebrovascular disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR T9	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 2-2, 19 89, to 2-5, 19 89, that (I) (we) last saw the deceased alive on 2-5, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C Stegman MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 2-5-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): C. STEGMAN MD. — 22e. ADDRESS: Mt. Vernon Road, Princess Anne, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2-8-89	23c. NAME OF CEMETERY OR CREMATORY: Sharptown Firemens Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Sharptown, Wicomico, MD
24. FUNERAL DIRECTOR NAME / ADDRESS: Zeller Funeral Home, Sharptown, MD 21861	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Tarr Johnson Registrar	

BP 2

DHMH 1650M 1/81 (VRA 15, 4)

123093 FEB 17 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006267
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ERNEST	MIDDLE	LAST: STACY	2a. DATE OF DEATH MONTH DAY YEAR: 1-27-89	2b. HOUR: 4:05 A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 11, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO COUNTY MD.		
10. CITY OR TOWN OF DEATH: SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES ☐ NO ☐	1514 Riverside Drive 21801

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS
Roland / / Stacey	Maggie / / Arvey		220-03-9010	1514 Riverside Drive, Md. Mrs. Mary H, Solum Stacey, Salisbury

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): COPD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): Heart failure

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/28 19 89 to 1/27 19 89 that (I) (we) last saw the deceased alive on ____ 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	1/30/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
MARK SKPEAKE, M.D.	106 Mt. Vernon rd., Princess Anne, Md. 21853

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/29/89	Beechwood Cemetery	Princess Anne, Md. 21853 Somerset

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James L. Wenna Princess Anne	JAN 30 '89	Freda Davidson-Randall

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

023321 FEB 2L

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06263
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Elmer; MIDDLE: ; LAST: Sterling				2a. DATE OF DEATH — MONTH: 01; DAY: 29; YEAR: 89	2b. HOUR: 10 50 PM
3. SEX: M	4. RACE: B	5. DATE OF BIRTH — MONTH: 5; DAY: 18; YEAR: 1915	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR — MONTHS: ; DAYS:	IF UNDER 24 HRS — HOURS: ; MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wicomico Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Seafood		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) — 13a. STATE: Md	13b. COUNTY: Som.	13c. CITY OR TOWN: Crisfield	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 332 Tyler St.	
14. FATHER'S NAME — FIRST: Joseph; MIDDLE: ; LAST: Sterling		15. MOTHER'S MAIDEN NAME — FIRST: Tillie; MIDDLE: M.; LAST: Milbourne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 220-09-1086	17. INFORMANT: Dorothy Lane	ADDRESS: Crisfield, Md 21817		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute MI

DUE TO, OR AS A CONSEQUENCE OF (b): HSVD

DUE TO, OR AS A CONSEQUENCE OF (c): Age

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-23, 19 89, to 1-29-89, 19 ____, that (I) (we) last saw the deceased alive on 1-29, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 1-30-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Hrthes — 22e. ADDRESS: 3 B my St Berlin

23a. BURIAL (SPECIFY), CREMATION, REMOVAL: 2/3/89	23b. DATE: 2/3/89	23c. NAME OF CEMETERY OR CREMATORY: Ebenezer	23d. LOCATION — CITY OR TOWN: Marumsco; COUNTY: Som.; STATE: Md	
24. FUNERAL DIRECTOR — NAME: Anthony E. Ward; ADDRESS: Crisfield Md.	25a. DATE REC'D. BY REGISTRAR: FEB 3 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP

DHMH-16 50M 1/81
(VRA 15, 4)

25165 MAR 13 91 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06269 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MADELINE	MIDDLE: L.	LAST: STERLING STERLING	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 28, 1989		2b. HOUR: 1704 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 18, 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: - -		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Somerset	Crisfield	YES [ ] NO [X]	Rt. 1 - Box 468 / 21817

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Harold	S.	Cullen	Dora	L.	Marshall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	- - -	214-03-5807	Kenneth W. Sterling, Sr.	same as 13abcde

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	MINUTES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	- RENAL FAILURE	DAYS.
DUE TO, OR AS A CONSEQUENCE OF (c)	- HEART FAILURE	WEEKS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
- 0 -	- 0 -	YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/17, 19 89, to 2/28, 19 89, that (I) (we) last saw the deceased alive on 2/28, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	3/22/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JO ANN BARTKOWICZ	145 E. Carroll St. - Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	03-03-89	Asbury Cemetery	Crisfield - Somerset - MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Bradshaw & Sons - - Crisfield, MD 21817	MAR 6 - 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

024330 FEB 29 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06270

1. DECEASED NAME (TYPE OR PRINT): First: Marie; Middle: C.; Last: Sturgis
2a. DATE OF DEATH: February 18, 1989
2b. HOUR: 1448 M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 9 14 1910
6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Pocomoke
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Rt.#2 Box 297 21851

14. FATHER'S NAME: First: J.; Middle: Edward; Last: Colona
15. MOTHER'S MAIDEN NAME: First: Eva; Middle: ; Last: Tull
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 213-10-3450
17. INFORMANT: Wilson Sturgis ADDRESS: Box 911 (20678) Prince Frederick, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Probable myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic renal failure, dementia

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 2/17 19 89 to 2/18 19 89, that (I) ~~(we)~~ last saw the deceased alive on 2/18 19 89, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Rodney A. Wenrich DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/18/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): RODNEY A. WENRICH
22e. ADDRESS: 100 POWER ST. SALISBURY, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/21/89
23c. NAME OF CEMETERY OR CREMATORY: First Baptist Cem.
23d. LOCATION CITY OR TOWN: Pocomoke COUNTY: Worcester STATE: Md.

24. FUNERAL DIRECTOR NAME: Scott S. Melson ADDRESS: PO BOX 64 Pocomoke, Md. 21851
25a. DATE REC'D. BY REGISTRAR: MAR 1 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1650M 1/81 (VRA 15, 4)

023958 FEB 2 0 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06271

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	RAYMOND RICHARD / TAYLOR, SR.	2a. DATE OF DEATH MONTH DAY YEAR	FEBRUARY 8, 1989	2b. HOUR	9:45 PM
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH MONTH DAY YEAR	Sept. 15, 1900
6. AGE (IN YEARS LAST BIRTHDAY)	88 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	WICOMICO MD.				
10. CITY OR TOWN OF DEATH	SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Mechanic
12b. KIND OF BUSINESS OR INDUSTRY	Fuel				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	Priscilla Street, 21801

14. FATHER'S NAME FIRST / MIDDLE / LAST	WESLEY / -- / TAYLOR	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	GEORGIA / -- / --

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		214-10-6580	Raymond R. Taylor, Jr.	409 Decator Ave. Salisbury, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lung Cancer

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C. J. Huddleston	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2-8-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
C. J. Huddleston	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	02-13-89	WICOMICO MEMORIAL	Salisbury / WI / MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HOLLOWAY Funeral HOme	501 Snow Hill Rd. Salisbury, MD	FEB 13 '89	

024974 MAR-8 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 89 06272

1. DECEASED NAME (TYPE OR PRINT): First John; Middle Salvatore; Last Testa
2a. DATE OF DEATH: Month February; Day 6; Year 1989
2b. HOUR: 10:30 AM
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: Month April; Day 26; Year 1912
6. AGE (IN YEARS LAST BIRTHDAY): ~~75~~ 76 YRS. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ~~XX~~ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales Manager
12b. KIND OF BUSINESS OR INDUSTRY: Appliances

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Berlin
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 57 Cresthaven, Ocean Pines

14. FATHER'S NAME: First Joseph; Middle; Last Testa
15. MOTHER'S MAIDEN NAME: First Josephine; Middle; Last Lavigno
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
16b. (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 103-09-5218
17. INFORMANT: Joseph Notarnicola
ADDRESS: 4673A Ocean Pines Berlin, Maryland 21811

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lung cancer
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: March 1987
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-3, 19 89, to 2-6, 19 89, that (I) (we) last saw the deceased alive on 2-6, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Inja J. Hwang
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/6/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Inja J. Hwang, M.D.
22e. ADDRESS: Deer's Head Center, Salisbury, MD. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial
23b. DATE: 02/11/89
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
23d. LOCATION: CITY OR TOWN; COUNTY; STATE: Berlin, Worcester, Maryland
24. FUNERAL DIRECTOR: NAME W. Kirk Burbage; ADDRESS 108 Williams Street Berlin, Maryland 21811
25a. DATE REC'D. BY REGISTRAR: FEB 8 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

C 023793 FEB 2 6 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006273

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KATHRYN MIDDLE: Virginia LAST: ULMAN			2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 4, 1989	2b. HOUR: 1650 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: APR. 02, 1916	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WASH. D.C.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.	
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired from C&P Phone Co.	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: WORCESTER	13c. CITY OR TOWN: Ocean City	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 1545 Teal Drive , 21842
14. FATHER'S NAME FIRST: WILLIE MIDDLE: BRYANT LAST: ENGLAND			15. MOTHER'S MAIDEN NAME FIRST: ANNIE MIDDLE: CHARLOTTE LAST: BEACH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 577-01-2372	17. INFORMANT: Harry Ulman	ADDRESS: 1545 Teal Drive Ocean City, MD 21842

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cavarian Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-4-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): N. EVINS W. TODD III	22e. ADDRESS: Med Cen Salisbury MD 21801		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 02-06-89	23c. NAME OF CEMETERY OR CREMATORY: Salisbury Crematory	23d. LOCATION CITY OR TOWN: Salisbury	COUNTY: WI STATE: MD
24. FUNERAL DIRECTOR NAME: Holloway Funeral HOme	ADDRESS: 501 Snow Hill Rd. Salisbury, MD	25a. DATE REC'D. BY REGISTRAR: FEB 07 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 56

DHMH - 1650M 1/81 (VRA 15, 4)

024962 MAR 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06274
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Myra	MIDDLE: Williams	LAST: Windsor Hill	2a. DATE OF DEATH MONTH: 02	DAY: 17	YEAR: 89
2b. HOUR: 10 35 pm					
3. SEX: Female	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 10 - 24 - 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico	MD.	
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wicomico Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b. KIND OF BUSINESS OR INDUSTRY: Farm Eq. Dealer		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: Crooked Oak Lane 21801	
14. FATHER'S NAME FIRST: Herbert	MIDDLE	LAST: Williams	15. MOTHER'S MAIDEN NAME FIRST: Beatrice	MIDDLE	LAST: Barnett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 214-09-9329	17. INFORMANT: Jane Davidson	ADDRESS: 325 S. Blvd. Salisbury Md 21801	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardio Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): PSVD

DUE TO, OR AS A CONSEQUENCE OF (c): Age

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1984, 19____, to Feb, 19 89, that (I) (we) last saw the deceased alive on Feb 21, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2-16-89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Arthes.	22e. ADDRESS: 3 Bay St Berlin 21813	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/22/1989	23c. NAME OF CEMETERY OR CREMATORY: Springhill Mem Gdns.	23d. LOCATION CITY OR TOWN: Fruitland	COUNTY / STATE: Md.
24. FUNERAL DIRECTOR NAME: Bounds Funeral Home ADDRESS: Salisbury Md.	25a. DATE REC'D. BY REGISTRAR: FEB 22 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle		

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached, because as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

024295 FEB 2 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06275
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): First: Hazel; Middle: Rowe; Last: Van Auken

2a. DATE OF DEATH: Month/Day/Year: February 18 1989

2b. HOUR: 0325 M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Month/Day/Year: April 23 1906

6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wxsox Pa.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: De

13b. COUNTY: Sussex

13c. CITY OR TOWN: Georgetown

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: R.D.#3 Box 496 99999

14. FATHER'S NAME: First: Walter; Middle: NMI; Last: Rowe

15. MOTHER'S MAIDEN NAME: First: Elizabeth; Middle: Middaugh; Last: Rowe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16a. (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 222 18 2818

17. INFORMANT: Wayne Van Auken ADDRESS: R.D.#3 Box 496 Georgetown De. 19947

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute renal failure

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Peripheral Vascular Disease

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 26 19 89 to Feb 18 19 89, that (I) (we) last saw the deceased alive on Feb 18 19 89, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Michael P. Buchness DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/18/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Michael P. Buchness

22e. ADDRESS: Medical Center West Suite 3 Bldg. 1 Wesley Drive Salisbury Md 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/20/1989

23c. NAME OF CEMETERY OR CREMATORY: Henlopen Mem. Park

23d. LOCATION: CITY OR TOWN: Milton; COUNTY: Sussex; STATE: De.

24. FUNERAL DIRECTOR: NAME: Willaim J. Esham ADDRESS: Georgetown De.

25a. DATE REC'D. BY REGISTRAR: MAR 1 - 1989

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

IMPORTANT: If Item 21 is marked on Item 18 showing any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH 16 50M 1/81 (VRA 15, 4)

023903 FEB 28 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062716 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: GEORGIOS	MIDDLE:	LAST: VELLIS	2a. DATE OF DEATH MONTH: FEBRUARY	DAY: 12	YEAR: 1989
2b. HOUR: 0435 M					
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 1 DAY: 15 YEAR: 38	6. AGE (IN YEARS LAST BIRTHDAY): 51 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS. HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GREECE	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE):	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD.	13b. COUNTY: WORCESTER	13c. CITY OR TOWN: OCEAN CITY	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET ADDRESS: 1106 Philadelphia Ave,	
14. FATHER'S NAME FIRST:	MIDDLE:	LAST:	15. MOTHER'S MAIDEN NAME FIRST:	MIDDLE:	LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 231-74-6517	17. INFORMANT ADDRESS: Fotios Vellis-11745 Athens Greece		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Brain stem infarction.
DUE TO, OR AS A CONSEQUENCE OF (c): Cerebro Atherosclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): CAD AMI SIP EARLY ; Ad smoke ;

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1/29/89, 19____, to 2/12/89, 19____, that (I) (we) last saw the deceased alive on 2/11/89, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/12/89.

22d. PHYSICIAN'S NAME (TYPE OR PRINT): H. R. HESA. 22e. ADDRESS: 614 D EASTERN SHORE Drive. SALISBURY. MD. 21801.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Removal	23b. DATE: 2-14-89	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
24. FUNERAL DIRECTOR NAME: State Anatomy Board	ADDRESS: Balto., Md.	25a. DATE REC'D. BY REGISTRAR: FEB 24 1989	25b. REGISTRAR'S SIGNATURE: Gina Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 16 50M 1/81 (VRA 15, 4)

0 2 3 3 1 8 FEB 21 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06277 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 12

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Morris	MIDDLE: C.	LAST: Warwick	2a. DATE OF DEATH MONTH: January	DAY: 31	YEAR: 1989
2b. HOUR: 1658 M					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: July	DAY: 4	YEAR: 1910	6. AGE (IN YEARS LAST BIRTHDAY): 78 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.		
10. CITY OR TOWN OF DEATH: SALISBURY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): PENINSULA GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): County Roads	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Somerset	13c. CITY OR TOWN: Upper Fairmount	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS: P.O. Box 201 21862	
14. FATHER'S NAME FIRST: Joseph	MIDDLE:	LAST: Warwick	15. MOTHER'S MAIDEN NAME FIRST: Gertrude	MIDDLE:	LAST: Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 215-36-0226	17. INFORMANT: Mrs. Opal Warwick	ADDRESS: P.O. Box 201 Upper Fairmount, Md	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Ventricular Asystole

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c): CAD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Small Bowel Obstruction / Septicemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. L. Raffetto	DEGREE: ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 1-31-89	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. L. RAFFETTO	22e. ADDRESS: QCH		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/3/89	23c. NAME OF CEMETERY OR CREMATORY: Beechwood	23d. LOCATION CITY OR TOWN: Pr. Anne	COUNTY: Somerset STATE: Md
24. FUNERAL DIRECTOR NAME / ADDRESS: Hinman Funeral Home, Princess Anne, Md	25a. DATE REC'D. BY REGISTRAR: JAN 31 89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

024961 MAR-8 89

1 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 06273

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and be made a part of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Items marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: George	MIDDLE: Wilson	LAST: Wharton	2a. DATE OF DEATH MONTH DAY YEAR: 02 14 1989	2b. HOUR: 5:20 P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 12 10 1918	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt. 5 Box 280 Quantico Rd.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Self Employed		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Wicomico	Salisbury	YES ☐ NO ☒	Rt.5 Box 280 21801

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	Washington	Wharton	Mollie		Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	------	214-10-7848	Gene Wharton	331 S. Tourmaline Dr. Hebron, Maryland 21830

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary failure	
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple Myeloma + MALIGNANT PLASMA Cytoma	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Anis Saliba, M.D.	Box 18 Lewes, Delaware 19958

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2-16-1989	Wicomico Mem. Park	Salisbury Wicomico MD

24. FUNERAL DIRECTOR (NAME) / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
BOUNDS FUNERAL HOME SALISBURY, MARYLAND	FEB 22 '89	Julia Davidson-Randall

BP 13

DHMH - 16 60M 7/84
(VRA 15, 4)

025248 MAR 14 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06279
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked for Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 4

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Rose	MIDDLE: Jane	LAST: Willey	2a. DATE OF DEATH MONTH DAY YEAR: 2-23-89	2b. HOUR: 7:50 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Aug 2, 1896	6. AGE (IN YEARS LAST BIRTHDAY): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: US	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico Co. MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Riverwalk Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 105 Times Square 21801	
14. FATHER'S NAME FIRST: Howard	MIDDLE:	LAST: Hopkins	15. MOTHER'S MAIDEN NAME FIRST: Rose	MIDDLE: Paul	LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 214-74-3707	17. INFORMANT: F. Paul Willey	ADDRESS: 429 Virginia Ave. Salisbury, Md. 21801	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from April 13, 19 87, to Feb 23, 19 89, that (I) (we) last saw the deceased alive on Feb 23, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas C Hill Jr.	DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/23/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS C. HILL JR	22e. ADDRESS: Pine Bluff Road, Salisbury, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/25/1989	23c. NAME OF CEMETERY OR CREMATORY: Old Trinity Church	23d. LOCATION CITY OR TOWN: Church Creek	COUNTY / STATE: Dor. Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: THOMAS FUNERAL HOME CAMBRIDGE, MD.		25a. DATE REC'D. BY REGISTRAR: FEB 27 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

024009 MAR-8 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062 80
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for the permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 in the Medical Certification (Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Pearl	MIDDLE: Ernestine	LAST: Wilson	2a. DATE OF DEATH MONTH DAY YEAR: February 17, 1989	2b. HOUR: 2 P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3-17-1935	6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Bivalve	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): At Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Unemployed	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Bivalve	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: Rt. 1 Box 35	21814
14. FATHER'S NAME FIRST: Ernest	MIDDLE: J.	LAST: Wilson	15. MOTHER'S MAIDEN NAME FIRST: Essie	MIDDLE: Pearl	LAST: Horner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ---	16b. SOCIAL SECURITY NO.: 217-30-9424	17. INFORMANT ADDRESS: Essie P. Eilson, Bivalve, Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ASPIRATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): FLU SYNDROME

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Schizophrenia, Treatment with Thioridazine

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 13 OCT 19 87 to FEB 19 89, that (I) (we) last saw the deceased alive on 14 FEB 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Stephen H Laffey	DEGREE: M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 20 FEB 89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Stephen H. Laffey M.D.		22e. ADDRESS: Nanticoke, Maryland 21840	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 2/20/89	23c. NAME OF CEMETERY OR CREMATORY: St Stephens Cem.	23d. LOCATION CITY OR TOWN: Delmar, Delaware COUNTY / STATE	
24. FUNERAL DIRECTOR NAME: Messick Funeral Home	ADDRESS: Bivalve, Md.	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE:	

BP 1

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 06231

023443 FEB 2 89

2. DECEASED NAME (TYPE OR PRINT): FIRST CHRISTINE MIDDLE MARIE LAST WINDER

2a. DATE OF DEATH: MONTH 1 DAY 27 YEAR 89

2b. HOUR: 10 P M

3. SEX: F

4. RACE: BLK

5. DATE OF BIRTH: MONTH OCT. DAY 14 YEAR 28

6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): md

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD.

10. CITY OR TOWN OF DEATH: SAN DOMINGO

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SAN DOMINGO RESIDENCE

12a. USUAL OCCUPATION (TYPE OF WORK DONE FOR MOST OF WORKING LIFE): RETIRED-SHIS

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: md

13b. COUNTY: WICO

13c. CITY OR TOWN: SAN DOMINGO

13d. INSIDE CITY LIMITS? YES ☐ NO ☑

13e. STREET ADDRESS / ZIP CODE: RT 1 MARDELA SPRINGS md. 21837

14. FATHER'S NAME: FIRST OLIS MIDDLE L. LAST HOPKINS

15. MOTHER'S MAIDEN NAME: FIRST FLORENCE MIDDLE HOPKINS LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): —

16b. (IF YES, GIVE WAR OR DATES):

16c. SOCIAL SECURITY NO.: 213-24-1965

17. INFORMANT: GERTRUDE WINDER ADDRESS: MARDELA md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LUNG CANCER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO, OR AS A CONSEQUENCE OF (b): METASTASIS TO LIVER — 1 month
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): MALNUTRITION

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-2 19 88 to 1-27 19 89, that (I) (we) last saw the deceased alive on 1-6 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: M.D. ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/1/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. D. MEADOWS M.D.

22e. ADDRESS: 506 Riverside Dr 3202 Salisbury MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 1-31-89

23c. NAME OF CEMETERY OR CREMATORY: ZION CH CEMETERY

23d. LOCATION: CITY OR TOWN SHARPTOWN COUNTY WICO STATE MD

24. FUNERAL DIRECTOR: NAME Fooks Funeral Home ADDRESS Salisbury

25a. DATE REC'D BY REGISTRAR: FEB 02 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 4

DHMH - 16 50M 4/83
(VRA 15, 4)

023957 FEB 28

1a FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 0 6 2 8 2 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST				2a. DATE OF DEATH KNOWN X / ESTIMATED ☐ MONTH / DAY / YEAR		2b. HOUR
Magellan		Worthington		2/09	1989	2010 M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH / DAY / YEAR	2d. HOUR
Male	Black	01 03 1909	80 YRS.			Feb 09 1989	2010 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
North Carolina	U.S.		Wicomico MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury	Peninsula General Hospital	Truck driver					

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS
Maryland	Worcester	Berlin		P.O.Box 202 21811

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Ernest Malachi Worthington	Lucy Geneva Bryant

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	--------	218-20-4379	Lillian Worthington, same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebrovascular Accident	minutes
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Cerebrovascular Disease	6 yrs +
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Carcinoma of prostate

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO X

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Thomas C Hill Jr. M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2/10/89

EXAMINER'S NAME (TYPE OR PRINT) Thomas C. Hill Jr. M.D. ADDRESS Pine Bluff Rd., Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2/14/89	Bethel Cemetery	Berlin Worcester Marylan

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Jolley Memorial Chapel Rt. #2, Box 920, Jersey Rd. Salisbury, MD 21801	FEB 13 '89	Julia Davidson-Register

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 6

DHMH - 17 (VR A15 ME (5))

022707 FEB 14 89 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06283 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: L.	LAST: Young	2a. DATE OF DEATH MONTH DAY YEAR: February 7, 1989	2b. HOUR: 10:25 M	
3. SEX: Male	4. RACE: BLK	5. DATE OF BIRTH MONTH DAY YEAR: 8 20 28	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): md	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: md	13b. COUNTY: Talbot	13c. CITY OR TOWN: Easton.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 424 South St	
14. FATHER'S NAME FIRST: Lewis MIDDLE: LAST: Young		15. MOTHER'S MAIDEN NAME FIRST: Ayphrinia MIDDLE: LAST: Hazelton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-24-4494	17. INFORMANT: Alice	ADDRESS: Camper	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Squamous cell carcinoma of rectum — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: April 1988
DUE TO, OR AS A CONSEQUENCE OF: (b) Extensive metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF: (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/6 19 89, to 2/7 19 89, that (I) (we) last saw the deceased alive on 2/7 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Inja J Hwang — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ — 22c. DATE SIGNED: 2/7/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Inja J. Hwang, M.D. — 22e. ADDRESS: Deer's Head Center, Salisbury, MD. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE: 2/11/89	23c. NAME OF CEMETERY OR CREMATORY: Paradise Cem.	23d. LOCATION CITY OR TOWN: Trappe / COUNTY: T / STATE: md	
24. FUNERAL DIRECTOR NAME: George W. Dashiell	ADDRESS: Easton md	25a. DATE REC'D. BY REGISTRAR: FEB 10 1989	25b. REGISTRAR'S SIGNATURE: Lisa Davidson-Kendall	

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

024895 MAR - 2 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 062841

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes" for Item 18, showing any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
MINNIE	B	Young	02 / 19 / 89	1235 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
female	Black	06 02 1895	93 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	U.S.A.		SALISBURY WICOMICO MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury	Deers Head Hospital Center				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET ADDRESS / ZIP CODE	
Md.	Dorchester	Cambridge		817 Washington St 21613	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Warren		Thomas	Georgianne		Stiles
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
		217-16-9023	Delores Ames		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septicemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Stage IV decubitus, rgld Hip

DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: senile Dementia. CA of the cervix, treated

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that ~~this~~ (this hospital) attended the deceased from 2-1, 19 89, to 2-19, 19 89, that ~~I~~ (we) last saw the deceased alive on 2/19, 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Constante J Tan	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	2/19/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
CONSTANTE J TAN	547 D Riverside Dr. Salisbury, MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/24/89	Bethel Cem	Cambridge	Dor.	Md.
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Stewart Funeral Home	Cambridge, Md.	FEB 22 '89	Julia Davidson-Handsell		

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024488 MAR - 1

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 06285

1. DECEASED NAME (TYPE OR PRINT): Brian (FIRST) Lee (MIDDLE) Atkins (LAST)

2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — MONTH 2 DAY 5 YEAR 19 89

2b. HOUR: M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH March DAY 15 YEAR 1971

6. AGE (IN YEARS LAST BIRTHDAY): 17 YRS.

IF UNDER 1 YR. MONTHS / DAYS

IF UNDER 24 HRS. HOURS / MIN.

2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 5 YEAR 19 89

2d. HOUR: 3:10 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester County MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): US Rt. 50/E. of Md. Rt. 589

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Automobile body work

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Howard

13c. CITY OR TOWN: Ellicott City

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET ADDRESS: 4805 South Haven Drive 21043

14. FATHER'S NAME (FIRST MIDDLE LAST): Gerald W Atkins

15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST): Carol A Lanahan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 217-78-1425

17. INFORMANT ADDRESS: Richard A. Anderson 4805 South Haven Dr. 21043

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple injuries

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

8150

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19: 2:50AM 2-5-89

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver of auto that ran off roadway

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: US Rt. 50/E. of Md.Rt. 589, Worcester Co.MD

22a. I certify that I took charge of the remains described above and on Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE OF MEDICAL EXAMINER: [signature]

TITLE (SPECIFY): Acting Deputy Chief

DATE SIGNED: 2-6-89

VC EXAMINER'S NAME (TYPE OR PRINT): Charles P. KOkes, M.D. ADDRESS: 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Feb 9, 1989

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge

23d. LOCATION CITY OR TOWN / COUNTY / STATE: Howard Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS: Harry H Witzke 4112 Old Columbia Rd Ellicott City

25a. DATE REC'D BY REGISTRAR: FEB 08 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WITHOUT DELAY, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 3

DHMH - 17 (VR A15 ME (5))

ITEM:14 per FH G-670
12/6/90 cm

024823 MAR-7 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062865
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	MARTHA	MacDONALD	BECKER	
2a. DATE OF DEATH MONTH DAY YEAR	FEB. 14, 1989			2b. HOUR M.
3. SEX	FEMALE			
4. RACE	WHITE			
5. DATE OF BIRTH MONTH DAY YEAR	12-20-1933			
6. AGE (IN YEARS LAST BIRTHDAY)	55 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	WASH., D.C.			
7b. CITIZEN OF WHAT COUNTRY?	USA			
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]				
9. BALTIMORE CITY OR COUNTY OF DEATH	SOMERSET Worcester MD.			
10. CITY OR TOWN OF DEATH	POCOMOKE City			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Dividing Rt.#1, Box 219-1, Creek Rd.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Home Economist Ext. Serv.			
12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MARYLAND			
13b. COUNTY	SOMERSET Worc.			
13c. CITY OR TOWN	Pocomoke City			
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]				
13e. STREET ADDRESS	Rt.1, Box219-1, Dividing Creek Road			
14. FATHER'S NAME FIRST / MIDDLE / LAST	~~RAYMOND~~ WILLIAM H ROBERTS	~~ANTHONY~~ McDONALD	~~BECKER~~	
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	MARTHA	VIRGINIA	ADKINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO			
(IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO.	217-32-2765			
17. INFORMANT ADDRESS	Raymond H. Becker Rt.#1, Box 219-1 Pocomoke City, MD			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma, of Unknown — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO, OR AS A CONSEQUENCE OF (b) Primary Origin
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 5 Oct. 19 88 to 14 Feb. 19 89, that (I) (~~we~~) last saw the deceased alive on 21 Dec. 19 88, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): James E. Martin M.D.

22e. ADDRESS: 145 E. Carroll St., Salisbury, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	CREMATION	23b. DATE	02-15-89	
23c. NAME OF CEMETERY OR CREMATORY	Salisbury Crematory			
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Salisbury WI MD			
24. FUNERAL DIRECTOR NAME / ADDRESS	Holloway Funeral Home 501 Snow Hill Rd. Salisbury, MD			
25a. DATE REC'D. BY REGISTRAR	FEB 16 '89			
25b. REGISTRAR'S SIGNATURE				

BP 10

DHMH - 1650M 1/81 (VRA 15, 4)

025227 MAR 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06287
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Dorothy	MIDDLE: E.	LAST: Cicero	2a. DATE OF DEATH MONTH: 2	DAY: 26	YEAR: 89
2b. HOUR: 11:25P M					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH: 1 DAY: 22 YEAR: 1909	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS	IF UNDER 1 YEAR MONTHS:	DAYS:
IF UNDER 24 HRS. HOURS:	MIN.:				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.		
10. CITY OR TOWN OF DEATH: Berlin	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Berlin Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY:		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 1310G Middle Neck Drive 21801	
14. FATHER'S NAME FIRST: Harry	MIDDLE:	LAST: Fowl	15. MOTHER'S MAIDEN NAME FIRST: Gertrude	MIDDLE: Pray	LAST: Fowl
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 160-09-3016	17. INFORMANT: D. BAYLY	ADDRESS: SALISBURY, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Candidiasis
DUE TO, OR AS A CONSEQUENCE OF (b): Multiple Myeloma
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 8/4 19 88 to 2/26 19 89 that (I) (we) last saw the deceased alive on 2/22 19 89 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2-27-89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Federico G. Arthes, M.D.
22e. ADDRESS: 3 Bay St., Berlin, MD 21811

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 3-2-89	23c. NAME OF CEMETERY OR CREMATORY: ST. DOMINICS	23d. LOCATION CITY OR TOWN: PHILA.	COUNTY: PA. STATE
24. FUNERAL DIRECTOR NAME: ULRICH F.H.	ADDRESS: BERLIN MD.	25a. DATE REC'D. BY REGISTRAR: FEB 21 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP 5

DHMH - 16 60M 7/84
(VRA 15, 4)

023985 FEB 28 89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062383
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Eleanor	Allred	Crawford	February 21, 1989	1225A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	Caucasian	03 29 19	69 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Washington, D. C.	United States	MARRIED X	Worcester MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Ocean City	10000 Coastal Highway	Attorney	Legal

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Worcester	Ocean City	YES X NO	10000 Coastal Highway/21842

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel		Allred	unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		288-07-1199	10000 Coastal Highway Warren Crawford, Ocean City, Maryland 21842

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Ventricular Fibrillation	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial infarction	Minutes
DUE TO, OR AS A CONSEQUENCE OF (c)	Atherosclerotic Vascular Disease	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

Alcoholism Chronic Organic Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES NO	YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
	19	

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19__ to 1/20, 19 89, that (I) (we) last saw the deceased alive on 1/20, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John G. Green	ATTENDING PHYSICIAN / MEDICAL DIRECTOR X / STAFF PHYSICIAN	2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John G. Green, MD	Locust and Quincy Streets, Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Removal	02/21/89	MD Board of Anatomy	Baltimore City, Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. Kirk Burbage	108 Williams Street Berlin, Maryland 21811	FEB 24 1989	Sara Davidson-Handelsman

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

023591 FEB 22 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

89 062289
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Annie	FLORENCE		JUSTICE	2	16	89	1225 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
Female	White	12	17	1902	86 YRS				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	USA		Worcester MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Snow Hill	Harrison House Nursing Home	Seamstress	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Virginia	Accomack	Greenbackville	YES ☐ NO ☒	rural 99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Hillary	D.	Sharpley	Jane		Davis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		219-05-9078	Hillary Justice	Rt.#1 Box 6 Snow Hill, Md. 21874

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Pulmonary arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic atrial fibrillation

DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Cerebrovascular disease & multiinfarct dementia; PVD; AODM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
James Joseph Carey	MD		2/16/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
James Joseph Carey	P.O. Box 640 P. Azle, MD 21653

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	2/19/89	Portersville Cem.	Stockton	Worcester	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Scott S. Milson	PO BOX 64 Pocomoke, Md. 21851	FEB 22 1989	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

99999

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

24578 MAR -3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 06290
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 6

DHMH - 17
(VR A15 ME (5))
30M 7/73

1. DECEASED NAME (TYPE OR PRINT)	FIRST: SIDNEY	MIDDLE: J.	LAST: KEITHLINE	2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐	MONTH: 2	DAY: 17	YEAR: 1989	2b. HOUR: M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: MONTH 11 DAY 22 YEAR 17	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: MONTH 2 DAY 17 YEAR 1989		2d. HOUR: M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): KANSAS	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD.						
10. CITY OR TOWN OF DEATH: OCEAN CITY	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 118 WINTER HARBOR	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ACCOUNTANT	12b. KIND OF BUSINESS OR INDUSTRY: GOVT.						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: WOR	13c. CITY OR TOWN: OCEAN CITY	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 18 WINTER HARBOR 21842					
14. FATHER'S NAME: FIRST SIDNEY MIDDLE M. LAST KEITHLINE	15. MOTHER'S MAIDEN NAME: FIRST LORETTA MIDDLE ANN LAST PRIEST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 511-18-9461	17. INFORMANT: M.A. KEITHLINE	ADDRESS: O.C. MD.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Alcoholism Chronic
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 2-18-89

EXAMINER'S NAME (TYPE OR PRINT): [illegible] Ankers ADDRESS: 3 Bay St Berlin

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	2-20-89	SUNSET, MA	BERLIN WOR MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ULRICH F.H. BERLIN, MD.	FEB 21 89	Gina Davidson-Mandell

025318 MAR 1 '89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 REG. NO. 06299

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Ruth	Elizabeth	Linton	2	27	89	6:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
Female	White	12	9	1913	75 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Virginia	U.S.A.		Worcester MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Snow Hill	Harrison House	Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Virginia	Accomac	Sanford	YES ☒ NO ☐	99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Willie		Trader	Isabelle		Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		224-14-8692	Joe B. Linton, Sanford, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Vascular collapse — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Status post CVA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) this hospital) attended the deceased from 2/15, 19 89, to 2/27, 19 89, that (I) (we) last saw the deceased alive on 2/23/89, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Paul Kogeulus — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED 3/1/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Kogeulus MD — 22e. ADDRESS Somerset Medical Center P.O. Box 640 Princess Anne MD 21853

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	3/2/89	Pt Federal Gardens	Oak Hall	Accomack	VA.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James N. Fox	Fox Funeral Home Temperanceville, VA 23442	MAR 01 '89	Jane Davidson-Randall

99999

BP

DHMH-16 50M 7/77 (VR A 15 (4))

023118 FEB 17 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

89 06292 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE BY WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR 19	2b. HOUR
Robert	Wayne	Makinen, II	2-		89	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19	2d. HOUR
Male	White	2/11/75	13 YRS.			2- 89	12:19 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA		Worcester County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Snow Hill	211 W. Federal Street	Student	Middle School				

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Worcester	Snow Hill	YES ☒ NO ☐	211 W. Federal St. / 21863

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Robert	W.	Makinen	Mary	Lee	Sparks

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-----	217 17 3354	Robert W. Makinen, Snow Hill, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound to head

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
		HEAD ONLY

21a. EXTERNAL CAUSE WAS UNDERLYING XX OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
	11:45PM 2-3-89	Self inflicted

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK XX	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	home	211 W. Federal Street, Snow Hill, Worcester Co Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Acting Deputy Chief MEDICAL EXAMINER DATE SIGNED 2-4-89

VC EXAMINER'S NAME (TYPE OR PRINT) Charles P. KOkes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	2/7/89	Whatcoat Methodist	Snow Hill, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Norman F. Dennis, Snow Hill, Maryland	FEB 06 '89	Julia Davidson-Randall

07/84 25M BP 3

DHMH - 17 (VR A15 ME (5))

022092 FEB-9 M3

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06293
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the burial-removal permit has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ADELINE	MARY	MARTINSEN	FEBRUARY 1, 1989	2220 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	CAUCASIAN	12 7 29	59 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
NEW JERSEY	UNITED STATES		WORCESTER MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BERLIN	9 HARPOON DRIVE OCEAN PINES	PSYCHIATRIC AIDE	HOSPITAL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	WORCESTER	BERLIN	YES [ ] NO [X]	9 HARPOON DRIVE OCEAN PINES 21811

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ROBERT	MOSES	MARKS	ADELINE		KESSLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		055-22-5473	ROBERT F. MARTINSEN	026 OCEAN PINES BERLIN, MARYLAND 21811

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Breast Cancer

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Lung Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Paul R Fleury	MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	2/2/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Paul R. Fleury, M.D.	560 Riverside Drive, Salisbury, MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	02/06/89	ST. JAMES METHODIST	ST. JAMES, SUFFOLK, NEW YORK

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. KIRK BURBAGE	108 WILLIAMS STREET BERLIN, MARYLAND 21811	FEB 7 1989	Gloria Davidson-Randall

15 BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

022930 FEB 16 1989

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 062941
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper and pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state. The medical examiner must be notified at once.

IMPORTANT: If Item 21a is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KATHERINE	MIDDLE: A.	LAST: McCABE	2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 8, 1989	2b. HOUR: 7:30 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: NOVEMBER 16, 1904	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DLEAWARE	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WOCESTER MD.	
10. CITY OR TOWN OF DEATH: BISHOPVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): BOX 96A SELBY ROAD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): FOOD HANDLER	12b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: DELAWARE	13b. COUNTY: NEW CASTLE	13c. CITY OR TOWN: WILMINGTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 100 SOUTH MARYLAND AVE. 99999
14. FATHER'S NAME FIRST: SAMUEL	MIDDLE: M.	LAST: SAUNDERS	15. MOTHER'S MAIDEN NAME FIRST: KATHERINE	MIDDLE:	LAST: KING
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES):	16b. SOCIAL SECURITY NO.: 222-03-6486	17. INFORMANT ADDRESS: KAY S. RUNYON, BISHOPVILLE, MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mistake the Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/2, 1989, to 2/8, 1989, that (I) (we) last saw the deceased alive on ____, 1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph A. GRASSO MD	22e. ADDRESS: 145 E. CARROLL St SALISBURY MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: FEB. 10, 1989	23c. NAME OF CEMETERY OR CREMATORY: CATHEDRAL CEM.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: WILMINGTON, NEW CASTLE, DE	
24. FUNERAL DIRECTOR NAME: Charles W Hastings	ADDRESS: HASTINGS F. H., SELBYVILLE, DE	25a. DATE REC'D. BY REGISTRAR: FEB 13 1989	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

025226 MAR 14 89

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 006295

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or knew.

BP 6

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Burton	L.	Powell	February 20, 1989	7:05 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
Male	White	February 12, 1916	73 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Worcester MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Newark	Rt. 1 - Box 72	Waterman	Seafood

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Worcester	Newark	YES ☐ NO ☒	Rt. 1 - Bos 72 / 21841

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Edgar	B.	Powell	Gertrude		Langmaid

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-----	217 36 0512	Grace V. Powell, Newark, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE 1a) Cardio pulmonary arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the prostate

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
Harold I. Genvert	MD	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
HAROLD I. GENVERT	16 Medical Center, Salisbury, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/23/89	Bowen Methodist	Newark, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Norman F. Dennis, Snow Hill, Maryland	FEB 21 '89	Julia Davidson Rendell

024575 MAR-3 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2 9 0 6 2 8 6

1. DECEASED NAME (TYPE OR PRINT): FIRST Richard MIDDLE G. LAST Reynolds

2a. DATE OF DEATH: MONTH 2 DAY 7 YEAR 89

2b. HOUR 11 50 PM

3. SEX: M

4. RACE: B 2

5. DATE OF BIRTH: MONTH 2 DAY 28 YEAR 09

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.

10. CITY OR TOWN OF DEATH: Pocomoke

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Home. Rt. 2

12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Laborer

12b. KIND OF BUSINESS OR INDUSTRY: Factory

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. 13b. COUNTY: Worcester 13c. CITY OR TOWN: Pocomoke 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS: Rt. 2 Bx. 326 21851

14. FATHER'S NAME: FIRST Albert MIDDLE LAST Reynolds

15. MOTHER'S MAIDEN NAME: FIRST Sallie MIDDLE LAST Long

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 217-16-9891

17. INFORMANT: Agnes Waters ADDRESS: Rt. 2 Bx. 326 Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PARKINSON Disease

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from _____, 19 80, to FEB 7, 19 89, that (I) (we) last saw the deceased alive on JAN 29 19 89, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Paul R Henry DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/9/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PAUL R FLEURY

22e. ADDRESS: 305 TENTH ST POCOMOKE City Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2-11-89

23c. NAME OF CEMETERY OR CREMATORY: St. James U.M. Cem

23d. LOCATION CITY OR TOWN: Pocomoke COUNTY: Wor. STATE: Md.

24. FUNERAL DIRECTOR NAME: Samuel H. Savage ADDRESS: New Church, Va.

25a. DATE REC'D. BY REGISTRAR: FEB 15 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP 3

DHMH - 16 50M 4/82
(VRA 15, 4)

022981 FEB 15 89

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 06297
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Victoria	MIDDLE: Anne	LAST: Rinaldi	2a. DATE OF DEATH MONTH DAY YEAR: February 7, 1989	2b. HOUR: 1020 A M	
3. SEX: Female	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: 11 30 25	6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS	IF UNDER 1 YEAR MONTHS DAYS:	IF UNDER 24 HRS HOURS MIN:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.		
10. CITY OR TOWN OF DEATH: Berlin	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Route 3, Box 573 X, Ironshire	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales agent	12b. KIND OF BUSINESS OR INDUSTRY: Real Estate		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Berlin	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: Route 3, Box 573X/21811	
14. FATHER'S NAME FIRST: Robert	MIDDLE	LAST: Rinaldi	15. MOTHER'S MAIDEN NAME FIRST: Anna	MIDDLE	LAST: Cardegna
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219-18-3011	17. INFORMANT: Susan Whittington	ADDRESS: Route 3, Box 573X Berlin, Maryland 21811	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Colon Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: JG Grasso	DEGREE: MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 2/9/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph Grasso, M.D.	22e. ADDRESS: 145 East Carroll Street, Salisbury, MD 21801		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): burial	23b. DATE: 02/10/89	23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Berlin, Worcester, Maryland
24. FUNERAL DIRECTOR NAME: W. Kirk Burbage	ADDRESS: 108 Williams Street Berlin, Maryland 21811	25a. DATE REC'D. BY REGISTRAR: FEB 14 1989	25b. REGISTRAR'S SIGNATURE: Julia Saunders

5 BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 89 062983

023597 FEB 23 '89

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Cornelia — MIDDLE: T. — LAST: Vaughn

2a. DATE OF DEATH — MONTH DAY YEAR: 02 12 1989 — 2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH — MONTH DAY YEAR: 12 15 1921

6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED X — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.

10. CITY OR TOWN OF DEATH: Pocomoke

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Route 2, Box 174

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Worcester — 13c. CITY OR TOWN: Pocomoke — 13d. INSIDE CITY LIMITS? YES ☐ NO X — 13e. STREET ADDRESS / ZIP CODE: Rt.#2, Box 174 21851

14. FATHER'S NAME — FIRST: Brinkman — MIDDLE: — LAST: Payne

15. MOTHER'S MAIDEN NAME — FIRST: Mae — MIDDLE: Leona — LAST: Pruitt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 213-12-5140

17. INFORMANT: Fred Vaughn — ADDRESS: Rt#2 Box 174 Pocomoke, Md. 21851

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sudden Death
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive Cardiovascular Dis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept, 19 88, to ____, 19 ____, that (I) (we) last saw the deceased alive on 11/2, 19 88, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul Fleury — DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 2/14/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): PAUL FLEURY

22e. ADDRESS: 305 Tenth St Pocomoke City

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/15/89

23c. NAME OF CEMETERY OR CREMATORY: Beth Eden Cemetery

23d. LOCATION — CITY OR TOWN: Pocomoke — COUNTY: Worcester — STATE: Md.

24. FUNERAL DIRECTOR NAME: Scott S. Milan — ADDRESS: PO BOX 64 Pocomoke, Md. 21851

25a. DATE REC'D BY REGISTRAR: FEB 20 1989

25b. REGISTRAR'S SIGNATURE: Julia Dawson-Lundell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

024576 MAR -3 '89

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 006299 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 3

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harrison	MIDDLE	LAST: Wright	2a. DATE OF DEATH MONTH: 02 DAY: 12 YEAR: 89	2b. HOUR: 2:55 P.M.	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH MO: 08 DA: 02 YR: 1902	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester County MD.		
10. CITY OR TOWN OF DEATH: Pocomoke	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Hartley Hall Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: DUPONT		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Eden	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt. 1 Box 188	
14. FATHER'S NAME FIRST: James	MIDDLE	LAST: Wright	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE	LAST: Moore
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 164-05-8947	17. INFORMANT: Glenmore Bivens	ADDRESS: Rt.#1, Box 188 Eden, MD 21822	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atherosclerotic Ventricular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ronald P. Travitz DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 2/13/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RONALD P. TRAVITZ MD 22e. ADDRESS: 560 RIVERSIDE DRIVE SALISBURY MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 2/18/89	23c. NAME OF CEMETERY OR CREMATORY: Wright's Cemetery	23d. LOCATION CITY OR TOWN: Eden	COUNTY: Somerset STATE: Maryland
24. FUNERAL DIRECTOR NAME: Jolley Memorial Chapel	ADDRESS: Rt.#2, Box 920, Jersey Road Salisbury, MD 21801	25a. DATE REC'D. BY REGISTRAR: FEB 16 '89	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	